

LEQVIO® Order Form

Fax Completed Form To:

Phone:

Amerita
YOUR INFUSION ADVOCATE

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
Address:		Referral Date:	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Secondary Contact:	Height:	Weight:	☐ Male ☐ Female
Allergies:			
PROVIDER INFORMATION			
Physician Name:		Lic.#:	
Practice Name:		DEA #:	
Address:		NPI#:	
City/State/Zip:			
Office Contact:	Phone:	Fax:	
Supervisory Physician (if applicable):			
DIAGNOSIS			
ICD 10 Code Required ☐ Atherosclerotic heart disease (ASVD), IC 10: I25.10 ☐ Familial Hypercholesterolemia (HeFH), IC 10: E78.01		☐ Other: _____ ICD 10: _____	
PLEASE ATTACH			
☐ Patient demographics & front/back copy of all insurance cards (prescription & medical) ☐ Recent office visit notes, history & physical, lab & pertinent procedure results ☐ Baseline blood level of LDL within the past 3 months ☐ Current medication list & list of prior medications tried and failed (with dates) ☐ Letter of medical necessity if drug dosing or indication is outside of FDA guidelines		☐ Patient currently on maximally tolerated statin therapy OR patient is not currently on statin therapy and has documented intolerance or contraindication to statin therapy. ☐ Current statin therapy: Drug name: _____ Dosage: _____ Start date or length of therapy: _____ ☐ Patient is on Zetia® (ezetimibe) in addition to statin therapy ☐ Patient is statin intolerant ☐ Patient has a contraindication for statin therapy: _____ ☐ Patient has been compliant with lipid lowering drug therapy and lifestyle modifications.	
For ASCVD: ☐ History of clinical atherosclerotic cardiovascular disease includes one or more of the following: ☐ ASCVD score ☐ Acute coronary syndrome ☐ Coronary artery disease (CAD) ☐ History of myocardial infarction (MI) ☐ Stable or unstable angina ☐ Coronary or other arterial revascularization ☐ Stroke ☐ Transient ischemic attack (TIA) ☐ Peripheral arterial disease (PAD) ☐ Other: _____		For HeFH: ☐ Confirmed by Simon Broome Register Diagnostic Criteria: _____ ☐ Mutation in LDLR, ApoB, PCSK9, or ARH adaptor protein (LDLRAP1) gene ☐ WHO/Dutch Lipid Clinic Network Score (DLCNS) > 8 points, Score: _____ ☐ Other: _____	
NURSING & LAB ORDERS			
Nurse Orders: Nurse to provide assessment, teaching, lab draws, medication administration and vascular access device insertion and/or management per physician orders.			
Lab Orders:		Lab Date & Frequency:	
PRESCRIPTION ORDERS			
Anaphylaxis Kit: ☐ Epinephrine 0.3mg IM as needed ☐ Solu-cortef 250mg-500mg IV infusion as needed ☐ Solu-Medrol 40-60mg via IM injection as needed (Check all that apply) ☐ Diphenhydramine _____ mg PO as needed ☐ NS Hydration 500 ml IV infusion over 30 minutes as needed ☐ Other			
Supply Orders: All supplies as appropriate to therapy will be provided as necessary.			
PRODUCT	PRESCRIPTION INFORMATION		REFILLS
Is this a first dose? ☐ Yes ☐ No If No, when was last dose given? _____ When is patient due for next dose? _____			
☐ LEQVIO	☐ Induction: 284mg SC injection at month 0 and 3 ☐ Maintenance: 284mg SC injection every 6 months <i>Also FDA approved for Homozygous Familial Hypercholesterolemia (HoFH)</i>		NONE
☐ OTHER			

Prescriber's Signature
Dispense as Written

Print Name

Date

Prescriber's Signature
Substitution Permitted

Print Name

Date



ACHC
ACCREDITED

