

# LEQVIO® Order Form

**Fax Completed Form To:****Phone:**

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

**Prescriber's Signature**  
**Dispense as Written**

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**Print Name**

Date \_\_\_\_\_

**Prescriber's Signature**  
**Substitution Permitted**

Print Name \_\_\_\_\_

Date \_\_\_\_\_