# LEQVIO Order Form

**Fax completed form to:** ____________________

## PATIENT INFORMATION

| Patient Name: | Date of Birth: | Referral Date: |
|---|---|---|
| Address: | City/State/Zip: | |
| Home Phone: | Cell Phone: | Work Phone: |
| Secondary Contact: | Height: Weight: | Male 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**

Atherosclerotic heart disease (ASVD), IC 10: I25.10

Familial Hypercholesterolemia (HeFH), ICD 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

**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 attach (TIA)
- Peripheral arterial disease (PAD)
- Other: ______________________

**Patient currently on maximally tolerated stain 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 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:** (Check all that apply)

- Epinephrine 0.3mg IM as needed
- Diphenhydramine ________ mg PO as needed
- Solu-cortef 250mg-500mg IV infusion as needed
- NS Hydration 500 ml IV infusion over 30 minutes as needed
- Solu-Medrol 40-60mg via IM injection 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 | NONE |
| | **Maintenance**: 284mg SC injection every 6 months | ________ |
| OTHER | | ________ |

***By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.***

| Prescriber's Signature<br>Dispense as Written | Print Name | Date | Prescriber's Signature<br>Substitution Permitted | Print Name | Date |
|---|---|---|---|---|---|

©2022 Amerita Inc. All rights reserved.

AME MOS LEQVIO ORDER FORM 06-30-22

ameritaiv.com mosaiciv.com

ACHC ACCREDITED