

LEQVIO® Referral 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), ICD 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: <table style="width:100%; border: none;"> <tr> <td style="width: 50%;">ASCVD score</td> <td style="width: 50%;">Coronary or other arterial revascularization</td> </tr> <tr> <td>Acute coronary syndrome</td> <td>Stroke</td> </tr> <tr> <td>Coronary artery disease (CAD)</td> <td>Transient ischemic attack (TIA)</td> </tr> <tr> <td>History of myocardial infarction (MI)</td> <td>Peripheral arterial disease (PAD)</td> </tr> <tr> <td>Stable or unstable angina</td> <td>Other: _____</td> </tr> </table>			ASCVD score	Coronary or other arterial revascularization	Acute coronary syndrome	Stroke	Coronary artery disease (CAD)	Transient ischemic attack (TIA)	History of myocardial infarction (MI)	Peripheral arterial disease (PAD)	Stable or unstable angina	Other: _____	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.		
ASCVD score	Coronary or other arterial revascularization														
Acute coronary syndrome	Stroke														
Coronary artery disease (CAD)	Transient ischemic attack (TIA)														
History of myocardial infarction (MI)	Peripheral arterial disease (PAD)														
Stable or unstable angina	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											
(Check all that apply)		Diphenhydramine _____ mg PO as needed		Solu-Medrol 40-60mg via IM injection 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				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 <u>Dispense as Written</u>	Print Name	Date	Prescriber's Signature <u>Substitution Permitted</u>	Print Name	Date
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