

LEQVIO ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs kg Sex: Male Female Allergies: NKDA, _____

Physician Name: _____ Contact Name: _____ Contact Phone #: _____

NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION)

Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

Does patient have venous access? YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER: _____

PRESCRIPTION ORDERS

- a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL POLICY PRN
- b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
<input type="checkbox"/>	LEQVIO (LOADING DOSES)	284 mg	SQ	Month 0 and 3, then every 6 months	
<input type="checkbox"/>	LEQVIO (MAINTENANCE DOSES)	284 mg	SQ	Every 6 months	

LABS

SELECT	LAB REQUESTED	FREQUENCY
<input type="checkbox"/>		
<input type="checkbox"/>		

SUPPORTING DOCUMENTATION FOR PATIENTS RECEIVING LEQVIO

- 1) SUPPORTING CLINICAL NOTES TO INCLUDE ANY PAST TRIED AND/OR FAILED THERAPIES, INTOLERANCE, BENEFITS, OR CONTRAINDICATIONS TO CONVENTIONAL THERAPY
- 2) HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) - DOES THE PATIENT HAVE A UNTREATED LDL \geq 190MG/DL (\geq 155MG/DL IF <16 YEARS OF AGE)? YES NO
- 3) PLEASE MARK ANY OF THE FOLLOWING CRITERIA THE HEFH PATIENT MEETS:
 - PRESENCE OF TENDON XANTHOMA(S) IN THE PATIENT OR 1ST/2ND DEGREE RELATIVE
 - FAMILY HISTORY OF MI AT <60 YEARS OLD IN 1ST DEGREE RELATIVE OR <50 YEARS OLD IN 2ND DEGREE RELATIVE
 - FAMILY HISTORY OF TOTAL CHOLESTEROL > THAN 290MG/DL IN A 1ST/2ND DEGREE RELATIVE
 - ARCUS CORNEALIS BEFORE AGE 45
- 4) ASCVD - DOES THE PATIENT'S LDL REMAIN \geq 100MG/DL DESPITE TREATMENT WITH A HIGH-INTENSITY STATIN? YES NO
- 5) HAS THE PATIENT TRIED AND FAILED PCSK9 INHIBITOR AFTER 12 WEEKS OF USE? YES NO
- 6) HAS THE PATIENT TRIED AND FAILED A HIGH INTENSITY STATIN FOR \geq 8 CONTINUOUS WEEKS? YES NO
- 7) INDICATE ANY CONDITIONS THE PATIENT HAS:
 - ACUTE CORONARY SYNDROME HISTORY OF MYOCARDIAL INFARCTION
 - CORONARY OR OTHER ARTERIAL REVASCULARIZATION TRANSIENT ISCHEMIC ATTACK
 - PERIPHERAL ARTERIAL DISEASE PRESUMED TO BE OF ATHEROSCLEROTIC ORIGIN STROKE
- 8) INCLUDE LABS AND/OR TEST RESULTS TO SUPPORT DIAGNOSIS
 - LDL-C (Required)
 - MUTATION IN LDL, APOB, OR PCSK9 GENE (If Applicable)
- 9) OTHER MEDICAL NECESSITY: _____

Physician's Signature _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____

*Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.