

**LEQVIO ORDER FORM**

Date: _____  Patient Name: _____  Date of Birth: _____	ICD-10 Code: _____  Allergies: _____  Weight: _____ lbs OR _____ kg
<b>Therapy Status</b>	<b>Provider Information</b>
New Start  <input type="checkbox"/> Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

**MEDICATION ORDER**

<input type="checkbox"/> Leqvio	Initiation and Maintenance Phase: Administer Leqvio 284mg subcutaneously at day zero, month three, then every six months.  <input type="checkbox"/> Maintenance Phase Only: Administer Leqvio 284mg subcutaneously every six months.	Refills x one year from date of signature unless indicated below.  <input type="checkbox"/> _____ refills	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:  ✓ Lipid panel within past 12 months
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**PRE-MEDICATIONS**

<input type="checkbox"/> Acetaminophen: ___325mg ___500mg ___650mg <input type="checkbox"/> Loratadine: 10 mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: ___25mg ___50mg <input type="checkbox"/> Famotidine: ___20mg ___40mg <input type="checkbox"/> Ibuprofen: ___200mg ___400mg ___600mg <input type="checkbox"/> Ondansetron: ___4mg ___8mg <input type="checkbox"/> Other _____	<input type="checkbox"/> Dexamethasone: ___4mg ___8mg <input type="checkbox"/> Diphenhydramine: ___25mg ___50mg <input type="checkbox"/> Famotidine: ___20mg ___40mg <input type="checkbox"/> Methylprednisolone 125mg <input type="checkbox"/> Hydrocortisone 100mg <input type="checkbox"/> Ondansetron: ___4mg ___8mg <input type="checkbox"/> Other _____
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**LAB ORDERS (Please indicate any labs to be drawn and frequency)**

**OTHER REQUIRED DOCUMENTATION**

**Surveillance lab ordering, and monitoring is the responsibility of the prescriber**	(Please fax this signed order form, along with the following documents to 800-223-4063)  <ul style="list-style-type: none"> <li>• History &amp; Physical, Last Office Visit Note</li> <li>• Patient Demographics and Insurance Information</li> <li>• Medication List</li> <li>• Recent Lab Work</li> </ul>
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**By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

Dispense as Written:  _____ Prescriber Name                      Date	Substitution Allowed:  _____ Prescriber Name                      Date
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