TwelveStone Health Partners
Fax Referral To:
(800) 223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

TwelveStone HEALTH PARTNERS ™

LEQVIO ORDER FORM

Date: ______________________	ICD-10 Code: ______________________
Patient Name: ______________________	Allergies: ______________________
Date of Birth: ______________________	Weight: ________lbs OR ________kg

Therapy Status	Provider Information
☐ New Start Previous Therapy: ______________ Date of Last Dose: ______________ Wash Out Period: ______________ ☐ Continuing Therapy: Last Dose: ______________	Ordering Provider: ______________ Provider NPI: ______________ Provider Phone: ______________ Provider Fax: ______________ Provider Address: ______________

MEDICATION ORDER

☐ Leqvio	☐ ***Initiation and Maintenance Phase:*** Administer Leqvio 284mg subcutaneosly at day zero, month three, then every six months. ☐ ***Maintenance Phase Only:*** Administer Leqvio 284mg subcutaneously every six months.	Refills x one year from date of signature unless indicated below. ☐ ________ 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: ✓ ***LDL within past six months***

PRE-MEDICATIONS

Oral

- ☐ Acetaminophen: ______ 325mg ______ 500mg ______650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: ______ 25mg ______ 50mg
- ☐ Famotidine: ______ 20mg ______40mg
- ☐ Ibuprofen: ______ 200mg ______400mg______600mg
- ☐ Ondansetron: ______ 4mg ______ 8mg
- ☐ Other: ______________________

IV

- ☐ Dexamethasone:______4mg ______8mg
- ☐ Diphenhydramine:______25mg______50mg
- ☐ Famotidine:______20mg ______40mg
- ☐ Methylprednisolone:______125mg
- ☐ Hydrocortisone: ______100mg
- ☐ Ondansetron: ______ 4mg ______ 8mg
- ☐ Other: ______________________

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:	Substitution Allowed:
Prescriber Name ______________ Date ______	Prescriber Name ______________ Date ______