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

LEQVIO ORDER FORM

Date: _____

Patient Name: _____

Date of Birth: _____

ICD-10 Code: _____

Allergies: _____

Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start
Previous Therapy: _____
Date of Last Dose: _____
Wash Out Period: _____

☐ Continuing Therapy:
Last Dose: _____

Provider Information

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:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date