

LEQVIO ORDER FORM

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

MEDICATION ORDER

<input type="checkbox"/> Leqvio	<input type="checkbox"/> 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 injection. If no results are available, the following labs will be drawn prior to first injection: ✓ LDL within past six months
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PRE-MEDICATIONS

<p>Oral</p> <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <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: _____	<p>IV</p> <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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<p>LAB ORDERS (please indicate any labs to be drawn and frequency)</p> <p><small>**Surveillance lab ordering and monitoring is the responsibility of the prescriber**</small></p>	<p style="text-align: center;">OTHER REQUIRED DOCUMENTATION</p> (Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
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By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

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