**TwelveStone Health Partners**
**Fax Referral To: (615) 278-3355 Direct**
**Phone: (844) 893-0012**
**Email: referral@12stonehealth.com**

# 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 for one year from date of signature unless indicated below.

_____ Refills

## 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)*

*By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.*

Dispense as Written:

_____ _____
Prescriber Signature Date

Substitution Allowed:

_____ _____
Prescriber Signature Date