

**TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com



**LEQVIO ORDER FORM**

Patient Name: _____	ICD-10 Code: _____
Date of Birth: _____	Allergies: _____
	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**

<b>Leqvio</b>	<input type="checkbox"/> <b>Initiation and Maintenance Phase:</b> Administer Leqvio 284mg subcutaneously at day zero, month three, then every six months.	Refills for one year from date of signature unless indicated below.  _____ Refills
	<input type="checkbox"/> <b>Maintenance Phase Only:</b> Administer Leqvio 284mg subcutaneously every six months.	
	<b>Has patient tried and failed a Statin and/or Repatha or Praluent to meet insurance step therapy requirements?</b>	
	<b>If so, please list:</b> _____	

**PRE-MEDICATIONS**

Oral	IV
<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: _____	<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: _____

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)  • 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.

_____ Prescriber Signature	_____ Date
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