Cumberland Vital Care

Fax Referral To:

(931) 456-4857

Direct Phone: (931) 456-0680

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 Ofice 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

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