

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

- 1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Medication List 5. Tried/Failed Therapies
- 6. Most Recent Labs 7. Are LDL levels elevated? Yes No 8. ASCVD Risk Score _____
- 9. Current Lipid Lowering Regimen _____

PRIMARY DIAGNOSIS

- E78.00 Pure hypercholesterolemia, unspecified E78.019 unspecified
- E78.2 Mixed hyperlipidemia E78.5 Hyperlipidemia, unspecified
- I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris Other _____
- E78.010 Homozygous familial hypercholesterolemia [HoFH]
- E78.011 Heterozygous familial hypercholesterolemia [HeFH]

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: There are no recommended standard pre-meds for Leqvio _____
- Provider Prescribed: _____

PRIMARY MEDICATION ORDER

- Leqvio 284mg SubQ at day 0, month 3, and every 6 months thereafter Leqvio 284mg SubQ every _____ months
- Other _____
- FIRST DOSE?: Yes No Refill x12 months unless otherwise noted _____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
- Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X

PROVIDER SIGNATURE _____ DATE _____