SHERIDAN COMMUNITY HOSPITAL
OUTPATIENT INFUSION CENTER
PHONE: 989.291.6295 FAX: 877.249.1191

☐ **STAT REFERRAL**

LEQVIO ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: ___ DOB: _____

HT: _____ in WT: _____ ☐ lbs ☐ kg Sex: ☐ Male ☐ Female Allergies: ☐ NKDA, _____

_____

Physician Name: _____ Contact Name: _____ Contact Phone #: _____

NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____ _____

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

PRESCRIPTION ORDERS

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL POLICY PRN
b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED FOLLOWING HOSPITAL POLICY

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
☐	LEQVIO (LOADING DOSES)	284 mg	SQ	Month 0 and 3, then every 6 months	
☐	LEQVIO (MAINTENANCE DOSES)	284 mg	SQ	Every 6 months	

LABS

SELECT	LAB REQUESTED	FREQUENCY
☐		
☐		

SUPPORTING DOCUMENTATION FOR PATIENTS RECEIVING LEQVIO

1) SUPPORTING CLINICAL NOTES TO INCLUDE ANY PAST TRIED AND/OR FAILED THERAPIES, INTOLERANCE, BENEFITS, OR CONTRAINDICATIONS TO CONVENTIONAL THERAPY

2) HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH) - DOES THE PATIENT HAVE A UNTREATED LDL ≥ 190MG/DL (≥ 155MG/DL IF <16 YEARS OF AGE)? ☐ YES ☐ NO

3) PLEASE MARK ANY OF THE FOLLOWING CRITERIA THE HEFH PATIENT MEETS:
   - ☐ PRESENCE OF TENDON XANTHOMA(S) IN THE PATIENT OR 1ST/2ND DEGREE RELATIVE
   - ☐ FAMILY HISTORY OF MI AT <60 YEARS OLD IN 1ST DEGREE RELATIVE OR <50 YEARS OLD IN 2ND DEGREE RELATIVE
   - ☐ FAMILY HISTORY OF TOTAL CHOLESTEROL > THAN 290MG/DL IN A 1ST/2ND DEGREE RELATIVE
   - ☐ ARCUS CORNEALIS BEFORE AGE 45

4) ASCVD - DOES THE PATIENT'S LDL REMAIN ≥ 100MG/DL DESPITE TREATMENT WITH A HIGH-INTENSITY STATIN? ☐ YES ☐ NO

5) HAS THE PATIENT TRIED AND FAILED PCSK9 INHIBITOR AFTER 12 WEEKS OF USE? ☐ YES ☐ NO

6) HAS THE PATIENT TRIED AND FAILED A HIGH INTENSITY STATIN FOR ≥ 8 CONTINUOUS WEEKS? ☐ YES ☐ NO

7) INDICATE ANY CONDITIONS THE PATIENT HAS:
   - ☐ ACUTE CORONARY SYNDROME
   - ☐ CORONARY OR OTHER ARTERIAL REVASCULARIZATION
   - ☐ PERIPHERAL ARTERIAL DISEASE PRESUMED TO BE OF ATHEROSCLEROTIC ORIGIN
   - ☐ HISTORY OF MYOCARDIAL INFARCTION
   - ☐ TRANSIENT ISCHEMIC ATTACK
   - ☐ STROKE

8) INCLUDE LABS AND/OR TEST RESULTS TO SUPPORT DIAGNOSIS
   - ☐ LDL-C (Required)
   - ☐ MUTATION IN LDL, APOB, OR PCSK9 GENE (If Applicable)

9) OTHER MEDICAL NECESSITY: _____

Physician's Signature _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Cosignature (If Required)_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.