US infusions
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LEQVIO INJECTION ORDERS

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

DIAGNOSIS AND ICD-10 CODE:

☐ E78.01 – Familial hypercholesterolemia

- ☐ Heterozygous familial hypercholesterolemia: untreated LDL >190mg/dL (>155mg/dL if <16 years of age)
- ☐ Presence of tendon xanthoma(s) in 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 >290mg/dL in 1st /2nd degree relative
- ☐ Arcus cornealis before age 45

☐ I25.10 – ASCHD w/o angina pectoris

☐ Other diagnoses: ☐ Acute coronary syndrome ☐ Coronary or other arterial revascularization
☐ History of myocardial infarction ☐ Peripheral arterial disease presumed to be of atherosclerotic origin
☐ Stroke ☐ Transient ischemic attack

PRESCRIPTION:

☐ 284mg subcutaneously initially, at 3 months, and then every 6 months (initial start) x 1 year

☐ 284mg subcutaneously every 6 months x 1yr

THERAPIES TRIED AND FAILED:

☐ High-intensity statin for >8 continuous weeks ☐ PCSK9 inhibitor; 12 weeks of use ☐ ASCVD – LDL remaining >70mg/dL despite treatment with a high-intensity statin

REQUIRED ASSOCIATED DOCUMENTATION:

☐ Patient demographics ☐ Front/back of all insurance cards ☐ Current medication list

☐ Include clinical notes supporting the above diagnoses.

☐ Include any clinical notes supporting additional secondary diagnoses.

☐ Include lab test results: ☐ LDL-C (required) ☐ Mutation in LDL, apoB, or PCSK9 gene (if applicable)

PROVIDER INFORMATION:

By signing this form, you authorize US Infusions and its staff to handle prior authorizations, coordinate with insurance providers, and determine the patient's preferred site of care.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

FAX COMPLETED FORM TO US INFUSIONS AT 469-200-2606