

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com



LEQVIO ORDER FORM

Date: _____

ICD-10 Code: _____

Patient Name: _____

Allergies: _____

Date of Birth: _____

Weight: _____ lbs OR _____ kg

Therapy Status

Provider Information

New Start
 Previous Therapy: _____
 Date of Last Dose: _____
 Wash Out Period: _____
 Continuing Therapy:
 Last Dose: _____

Ordering Provider: _____
 Provider NPI: _____
 Provider Phone: _____
 Provider Fax: _____
 Provider Address: _____

MEDICATION ORDER

Leqvio

- Initiation and Maintenance Phase:**
 Administer Leqvio 284mg subcutaneously at day zero, month three, then every six months.
- Maintenance Phase Only:**
 Administer Leqvio 284mg subcutaneously every six months.

Refills for one year from date of signature unless indicated below.

_____ Refills

Please include the following lab results required for injection. If no results are available, the following labs will be drawn prior to first injection:

✓ **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)

OTHER REQUIRED DOCUMENTATION

(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.

Dispense as Written:

Substitution Allowed:

Prescriber Name _____

Date _____

Prescriber Name _____

Date _____