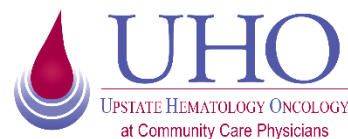


Leqvio



Ph:: 518-836-3030 | Fax: 518-836-3020

Date: _____

Please include the following to
expedite the order

Demographics, Insurance Information, Last Progress Note
Relevant to the Diagnosis, Current Medications, Lipid Panel

PATIENT INFORMATION

PRESCRIBER INFORMATION

Patient Name: _____

Prescriber's Name: _____

Patient Contact Number: _____

NPI: _____ Date: _____

DOB: _____

Phone: _____ Fax: _____

Allergies: _____

Office Address: _____

Weight: _____ ○ lbs ○ kg Height: _____

Contact Person: _____

Diagnosis: _____

Contact Email: _____

ICD 10: _____

☐ Please check this box if you **DO NOT** authorize UHO to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

PREMEDS

Pre-Medications not usually indicated

☐ No Premeds

Benadryl: ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

Acetaminophen: ☐ PO ☐ 650 mg ☐ Other: _____

Methylprednisolone: ☐ IV ☐ _____ mg

Other: _____

☐ You authorize UHO to utilize the hypersensitivity protocol established by UHO.

Signature: _____

Date: _____

LEQVIO DOSAGE

Date of Last Treatment, if Continuation: _____

Route: Subcutaneous Injection

Dose: 284 mg/1.5 mL Pre-Filled Syringe

Frequency: ☐ 0, 3 months, then every 6 months

☐ Every 6 months

Refills: ☐ 3 months ☐ 6 months ☐ 12 months

(if not indicated order will expire 6 months from date signed)

To ensure that a Brand name product be dispensed, the prescriber must handwrite “Brand Medically Necessary” on prescription form. If not indicated, UHO is authorized to administer generic or biosimilar.

LAB ORDERS

☐ No Labs

List: _____

Frequency: _____

Signature: _____

Date: _____