Leqvio® Provider Order Form Updated 06/2022

Please fax completed referral order form & all required documents to **281-295-4051**

AguaVivir
www.aguavivir.com

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Atherosclerotic heart disease (ASCVD), I25.10

☐ Familial Hypercholesterolemia (HeFH), E78.01

☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Leqvio® (inclisiran)	284 mg	**INITIAL:** ☐ First dose: Inject SubQ x 1 dose ☐ Second dose at 3 months: Inject SubQ x 1 dose **MAINTENANCE:** ☐ Inject SubQ every 6 months x 1 year

Is patient currently receiving therapy above from another facility?

☐ NO ☐ YES

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO

☐ Diphenhydramine 25mg PO

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ LDL-C q _____ ☐ Lipid Panel q _____

☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

☐ **See Attached Medical Records**

☐ Yes ☐ No Is the patient's LDL-C level elevated despite treatment with maximally tolerated statin therapy?

- Recent LDL-C level: _____ mg/dL; Date lab drawn: _____ ***(Attach copy of labwork)***

☐ Yes ☐ No Is the patient currently on maximally tolerated statin therapy -**OR**- Is patient not currently on statin therapy and has documented intolerance or contraindication to statin therapy?

- ☐ Current statin therapy; Drug name: _____ Dosage: _____ Start date or Length of Therapy: _____
  - ☐ Check box if patient is on Zetia® (ezetimibe) in addition to statin therapy.
- ☐ Patient is statin intolerant (list failed statin therapies and reasons below)
- ☐ Patient has a contraindication for statin therapy, specify: _____

☐ Yes ☐ No Has the patient been compliant with lipid lowering drug therapy and lifestyle modifications?

For ASCVD:

History of clinical atherosclerotic cardiovascular disease includes one of more of the following: ***(Select all that apply)***

☐ Acute coronary syndrome
☐ Coronary artery disease (CAD)
☐ History of myocardial infarction (MI)
☐ Stable or unstable angina
☐ Coronary or other arterial revascularization
☐ Stroke
☐ Transient ischemic attack (TIA)
☐ Peripheral arterial disease (PAD)
☐ Other: _____

For HeFH:

HeFH confirmed by:

☐ Mutation in LDLR, ApoB, PCSK9, or ARH adaptor protein(LDLRAP1) gene ***(Attach copy of test results)***

☐ WHO/Dutch Lipid Clinic Network Score (DLCNS); Score: _____ ***(Attach copy of assessment)***

☐ Other: _____

LAB RESULTS (required)

☐ LDL cholesterol blood level

PRIOR FAILED THERAPIES (including statins and PCSK9 inhibitors)

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____