Southwestern Medical Center
Empowered by ScionHealth
Phone: 580-531-4892
Fax: 877-249-1191

☐ **STAT REFERRAL**

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
LEQVIO ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI____ DOB:_____

HT: _____ in WT: _____ 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.