

Los Angeles, CA
2080 Century Park East
Suite 710
Los Angeles, CA 90067



(evinacumab-dgnb)

EVKEEZATM

Infusion orders

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

DIAGNOSIS (and ICD 10 code)

Homozygous familial hypercholesterolemia (HoFH) ICD 10 Code: E78.01

Other: _____ ICD 10 Code: _____

NOTE

List Tried & Failed Therapies, including duration of treatment:

1)

2)

EVKEEZATM ORDERS

DOSE:

15mg/kg

_____mg Calculated dose

Max volume of 250ml 0.9%NS or D5W

Other _____

FREQUENCY

Over 1 hour

Dose every 4 weeks

Dose every _____

TOTAL DOSES:

6 months _____ 1 yr _____ Other _____ Refill _____

PATIENT WEIGHT

_____ lbs.

_____ kg

REQUIRED DOCUMENTATION:

This signed order form by the provider

Patient demographics AND insurance information

Clinical/Progress notes supporting primary diagnosis

Confirmation of homozygous familial hypercholesterolemia

Confirmation of negative pregnancy test in females

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____