Connecticut
500 W Putnam Ave
Ste 435
Greenwich, CT 06830

Office: 212-803-3339 Fax : 646-768-8600

(evinacumab-dgnb)

EVKEEZA™

Infusion orders

Date: ____________________

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS				
☐New Referral	☐Referral Renewal	☐Medication/Order Change	☐Benefits Verification Only	☐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)

EVKEEZA™ 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 ______________