

(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 _____