

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



(evinacumab-dgnb)

EVKEEZA™

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

- 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 _____