

Date: \_\_\_\_\_ Treatment Location: \_\_\_\_\_

**PROVIDERS: Please include the following to expedite the order.**

Most Recent Office Visit Note, Insurance Info, Medication List, and cholesterol labs

Tried & Failed Medications: Statins: \_\_\_\_\_ Lipid Lowering Treatment: \_\_\_\_\_

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_

Patient Contact Number: \_\_\_\_\_

DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs / kg Height: \_\_\_\_\_

Diagnosis:  E78.01

Other Dx/ICD10: \_\_\_\_\_

### PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_

**Signature:** \_\_\_\_\_

NPI: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Office Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Contact Email: \_\_\_\_\_

### The following medications will be administered per prescribing information:

No Premeds

**Center will use Hypersensitivity protocol established by Infusion for Health and P.I.**

### EVKEEZA DOSAGE

Patient Weight in KG: \_\_\_\_\_

\_\_\_\_\_ **15 mg/kg administered IV every 4 weeks** Route:  IV

*To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.*

**Lab Orders:**  Cholesterol profile  Other: \_\_\_\_\_

Prior to first appointment  Other Frequency: \_\_\_\_\_

Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.