Evkeeza
(Evinacumab)

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics; Insurance Information; All Clinical Documentation Supporting the Diagnosis Including Any Previous or Current Therapies, Pertinent Labs, or Diagnostic Testing; Recent Lipid Panel

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ E78.010 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

☑ Deliver patient care in accordance with Infusion for Health clinical procedures and the medication's prescribing information (PI), including management of hypersensitivity reactions

☑ Current Cholesterol-Lowering Treatment:

_____

PRE-MEDICATION ORDERS

Pre-medications not usually indicated.

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

LABORATORY ORDERS

☐ Cholesterol Profile ☐ at each dose ☐ every _____

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ 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.

THERAPY ADMINISTRATION

☑ Evkeeza Intravenous Infusion

Dose: 15mg/kg

Frequency: Once every 4 weeks

☑ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) | Provider Signature | Date

☐ ***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.***