

Evinacumab-dgnb (Evkeeza)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____

Patient Address: _____ Patient Email: _____

Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____

Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

Homozygous familial hypercholesterolemia: _____

THERAPY ADMINISTRATION

Administer Evkeeza 15mg/kg _____ mg IV in 100ml to 250ml of 0.9%NS or D5W over 60 minutes every 4 weeks

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

- Tylenol 500mg / 650mg PO
- Loratadine 10mg PO
- Pepcid 20mg PO / IVP
- Benadryl 25mg / 50mg PO / IVP
- Solumedrol 40mg / 125mg IVP
- Other: _____

NURSING

- Hold infusion and notify provider if there is a chance pt is pregnant.
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation
- Record Vital signs prior to discharge

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with statins and any other lipid lowering agent, allergies, cardiac history, History of CAD, MI, TIA, Stroke, or cardiac catheterization.

Required Labs: LDL, full lipid panel, and cholesterol levels

Provider Name (print)

Provider Signature

Date