Patient Name:______________________________________

DOB:______________________ Wt(kg):_________________

Allergies:____________________ Phone:_________________

Evkeeza (evinacumab-dgnb) Infusion Orders

Required Information:

Signed order from prescribing provider

Patient demographics including insurance information

Supporting clinical documentation: Visit notes, diagnostic results

Primary Diagnosis:

Homozygous Familial Hypercholesterolemia (ICD-10 :___________)

Other:________________(ICD-10:_____________)

EVKEEZA ORDERS

Evkeeza 15mg/kg IV every 4 weeks

Evkeeza _____________ every _____ weeks

Date of Last Evkeeza:_________

Administered per manufacturer guidelines

PRE-MEDICATIONS

PO Tylenol _____mg

PO Cetirizine _____mg

IV Solu-medrol _____mg

PO Loratadine _____mg

PO IV Diphenhydramine _____mg

PO IV Other:______________ _____mg

LABS

CBC	ESR	Uric Acid
CMP	TB Quantiferon Gold	Other:______
CRP	Hep B Core/Surface AG	Other:______

Frequency: Every Visit

Every Other Visit

One time only

Other:_____________

CPL Acct #:___________

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

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Physician Name:	**Phone:**	**Fax:**
Physician Signature:	**NPI:**	**Date:**