Evkeeza® Order Form
(evinacumab-dgnb)

FAX TO: 866.746.3890

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F

Ht: _____ Wt: _____☐ lbs ☐ kg Primary Language: _____

Allergies: _____Patient Preferred Location: _____

Diagnosis

ICD 10 Code Required

☐ E78.19 Familial Hypercholesterolemia, Uunspecified

Other: _____ ICD 10: _____

Medication Order

DOSING

15 mg/kg every 4 weeks x 1 year

PRE-MEDICATION ORDERS

☐ Acetaminophen 650 mg PO
☐ Cetirizine 10 mg PO
☐ Diphenydramine 25 mg PO
☐ Diphenydramine 25 mg IV
☐ Methylprednisolone _____ mg

Lab Orders

Requested Add'l Lab Orders:

_____

_____

Lab Frequency: _____every _____weeks

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No

If yes, please note therapy and last dose:

_____

Required Clinical Documentation

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis

Clinical information, select all that apply:

For all diagnoses

☐ The patient's LDL-C level is elevated despite treatment with maximally tolerated statin therapy
- Recent LDL-C level: _____ mg/dl; Date lab drawn: _____

☐ The patient is currently on statin therapy
- ☐ Current statin therapy; Drug name: _____ Dosage: _____ Start Date or Length of Therapy: _____
  - ☐ Check box if patient is on Zetia® (ezetimibe) in addition to statin therapy

☐ The patient is ***not*** currently on statin therapy and has documented intolerance or contraindication to statin therapy
- ☐ Patient is statin intolerant (List failed statin therapies and reasons below)
- ☐ Patient has a contraindication for statin therapy, specify: _____

☐ The patient has been compliant with Lipid lowering drug therapy and lifestyle modifications

For HeFH only

HeFH confirmed by: ☐ Mutation in LDLR, ApoB, PCSK9, or ARH adaptor protein(LDLRAP1) gene ***(Attach copy of assessment)***
☐ WHO/Dutch Lipid Clinic Network Score (DLCNS); Score: _____ ***(Attach copy of assessment)***
☐ Other: _____

LAB RESULTS (required)

☐ LDL cholesterol blood level ***Medix Infusion will collect all necessary labs if not included in referral documents***

PRIOR FAILED THERAPIES (including statins and PCSK9 inhibitors)

Medication: _____ Dates of Treatment: _____
Reason for D/C: _____
Medication: _____ Dates of Treatment: _____
Reason for D/C: _____

Patient has received dietary counseling related to hyperlipidemia and CV disease

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____