Evinacumab-dgnb (Evkeeza)

Provider Order Form rev. 10/30/2023

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

LABORATORY ORDERS

☐ Monitor LDL-C levels ☐ every 2 weeks ☐ every 4 weeks
☐ Other: _____

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**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.