RESTORE HEALTH
INFUSION AND WELLNESS

EVKEEZA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ **DOB**: _____ **Gender**: ☐ M ☐ F ☐ Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER

Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

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

Phone: _____ **Fax:** _____

CLINICAL

Diagnosis: ☐ E78.01 (Familial Hypercholesterolemia) ☐ Other: _____

Allergies: _____ **Weight:** _____ ☐ kg ☐ lbs **Height:** _____ ☐ cm ☐ in

Current Cholesterol-Lowering Treatment: _____

CBC Completed: ☐ Yes ☐ No **CMP/LFTs Completed:** ☐ Yes ☐ No **Lipid Panel Completed:** ☐

TREATMENT

EVKEEZA (evinacumab-dgnb)

Route: Intravenous Infusion

Dose: ☐ 15mg/kg

Frequency:

☐ Once every 4 weeks

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

■ *Center will use anaphylactic and hypersensitivity protocol established by Restore Health*

Special Instructions: _____

Quantity: _____ **Refills:** _____

Provider Signature: _____ Date: _____