RESTORE HEALTH
INFUSION AND WELLNESS

EVKEEZA

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

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

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

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

PRESCRIBER INFORMATION

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

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

Phone: _____ **Fax:** _____

CLINICAL INFORMATION

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 INFORMATION

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: _____

Special Instructions: _____

Quantity: _____ **Refills:** ____

Provider Name: _____ Provider Signature: _____ Date: _____