

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ SEX:  M  F HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_  LBS  KG  
ALLERGIES: \_\_\_\_\_ PREFERRED CLINIC: \_\_\_\_\_  
REFERRAL STATUS:  NEW REFERRAL  ORDER CHANGE  ORDER RENEWAL

**DIAGNOSIS & CLINICAL DOCUMENTATION**

K50.00 Homozygous familial hypercholesterolemia (HoFH)  
 ICD-10 CODE: \_\_\_\_\_ DESCRIPTION: \_\_\_\_\_

**REQUIRED DOCUMENTATION**

Insurance Information  List of Medications  Tried & Failed Therapies  Most Recent History & Physical  
 Negative pregnancy test in females

**MEDICATION ORDER**

Evkeeza® (evinacumab) 15mg/kg IV in 250ml NS over 60 minutes every 4 weeks

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE:  
\_\_\_\_\_

**PRE-MEDICATIONS**

**PO**  
 Acetaminophen: 650 mg  
 Cetirizine: 10 mg  
 Diphenhydramine: 25 mg  
**IV**  
 Methylprednisolone: 125 mg  
 Diphenhydramine: 25 mg  
 OTHER: \_\_\_\_\_  PO  IV

Patient to be observed for 30 minutes following the first administration. Administer per protocol. In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

**PRESCRIBER INFORMATION**

PROVIDER NAME: \_\_\_\_\_ NPI #: \_\_\_\_\_  
EMAIL: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_  
ADDRESS (INCLUDE CITY, STATE, ZIP): \_\_\_\_\_  
SUPERVISING PHYSICIAN: \_\_\_\_\_ CONTACT NAME: \_\_\_\_\_  
(IF APPLICABLE)  
SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(NO STAMPS)

SUBSTITUTION PERMITTED | DISPENSE AS WRITTEN