MIC | METRO INFUSION CENTER

INFUSION ORDERS- EVKEEZA™ (evinacumab-dgnb)

PATIENT INFORMATION		
Name:	DOB:	Dosing Weight:
Allergies:	Date of Referral:	

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/

DIAGNOSIS AND ICD 10 CODE
☐ Homozygous familial hypercholesterolemia (HoFH) ICD 10 Code: E78.01 ☐ Other: _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider ☐ Patient demographics AND insurance information	☐ Clinical/Progress notes supporting primary diagnosis ☐ Confirmation of homozygous familial hypercholesterolemia ☐ Confirmation of negative pregnancy test in females
List Tried & Failed Therapies, including duration of treatment: 1) 2)	

MEDICATION ORDERS					
EVKEEZA™ (evinacumab-dgnb)	15mg/kg	_____mg Calculated dose	Max volume of 250ml 0.9%NS or D5W	Over 1 hour	Every 4 weeks
EVKEEZA™ (evinacumab-dgnb)	_____mg		Max volume of 250ml 0.9%NS or D5W	Over 1 hour	Every 4 Weeks
Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses					

PHYSICIAN INFORMATION		
Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

Fax referral to (866) 507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this form is strictly confidential and will become part of the patient's medical record.

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