TN
100 Covey Drive
Suite 307
Franklin, TN 37067

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

(evinacumab-dgnb)

EVKEEZA™

Infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

DIAGNOSIS *(and ICD 10 code)*

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

NOTE

List Tried & Failed Therapies, including duration of treatment:
1)
2)

EVKEEZA™ ORDERS

DOSE:
- ☐ 15mg/kg
- ☐ _____mg Calculated dose
- ☐ Max volume of 250ml 0.9%NS or D5W
- ☐ Other_____

FREQUENCY
- ☐ Over 1 hour
- ☐ Dose every 4 weeks
- ☐ Dose every_____

TOTAL DOSES:

☐ 6 months _____ ☐1 yr _____ ☐ Other_____ ☐Refill _____

PATIENT WEIGHT

_____ lbs.
_____ kg

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

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____