

# Evinacumab-dgnb (Evkeeza)

Provider Order Form rev. 2/4/26



## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height: \_\_\_\_\_

Patient Status:  New to Therapy  Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## NURSING

- Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
- NOTE:** IVX Adverse Reaction Management Protocol available for review at [www.ivxhealth.com/forms](http://www.ivxhealth.com/forms) (version 05.01.2023)

## LABORATORY ORDERS

- CBC  at each dose  every \_\_\_\_\_
- CMP  at each dose  every \_\_\_\_\_
- CRP  at each dose  every \_\_\_\_\_
- Other: \_\_\_\_\_

## PRE-MEDICATION ORDERS

- acetaminophen (Tylenol)  500mg /  650mg /  1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl)  25mg /  50mg  PO /  IV
- methylprednisolone (Solu-Medrol)  40mg /  125mg IV
- Other: \_\_\_\_\_
- Dose: \_\_\_\_\_ Route: \_\_\_\_\_
- Frequency: \_\_\_\_\_

## THERAPY ADMINISTRATION

- Evinacumab-dgnb (Evkeeza) Intravenous infusion
- Dose: 15mg/kg IV
- Frequency: Once every 4 weeks
- Flush with 0.9% NS at the completion of infusion
- Patient is required to stay for 30-minute observation
- Refills:  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated order will expire one year from date signed)

## APPEALS PROCESS

Upon denial, IVX will appeal with a Letter of Medical Necessity unless you opt out:  Opt out (I will manage any denial)

## SPECIAL INSTRUCTIONS

Provider Name (Print)

Provider Signature

Date

<b>IVX HEALTH FAX NUMBERS</b>	<input type="checkbox"/> CINCINNATI: 844-946-0868	<input type="checkbox"/> FT. LAUDERDALE: 754-946-2052	<input type="checkbox"/> MIAMI: 786-744-5687	<input type="checkbox"/> PIEDMONT TRIAD: 336-790-2200
	<input type="checkbox"/> COLLEGE STN: 979-205-4686	<input type="checkbox"/> HARRISBURG: 844-859-4235	<input type="checkbox"/> MIDDLE/WEST TN: 888-615-1445	<input type="checkbox"/> RALEIGH: 919-287-2551
	<input type="checkbox"/> COLUMBUS: 844-627-2675	<input type="checkbox"/> HOUSTON: 832-631-9595	<input type="checkbox"/> NORTH CENTRAL FL: 352-756-4191	<input type="checkbox"/> SAN ANTONIO: 726-238-9950
	<input type="checkbox"/> ARKANSAS: 501-451-5644	<input type="checkbox"/> CONNECTICUT: 860-955-1532	<input type="checkbox"/> INDIANAPOLIS: 844-983-2028	<input type="checkbox"/> NORTH JERSEY: 551-227-2823
	<input type="checkbox"/> AUSTIN: 512-772-2824	<input type="checkbox"/> DALLAS: 469-947-6114	<input type="checkbox"/> JACKSONVILLE: 904-212-2338	<input type="checkbox"/> NYC: 332-334-0809
	<input type="checkbox"/> BAY AREA: 844-889-0275	<input type="checkbox"/> DAYTONA: 386-259-6096	<input type="checkbox"/> KANSAS CITY: 844-900-1292	<input type="checkbox"/> ORLANDO: 844-946-0867
	<input type="checkbox"/> CHARLOTTE: 336-663-0143	<input type="checkbox"/> DELAWARE: 302-596-8553	<input type="checkbox"/> LAKELAND: 863-316-3910	<input type="checkbox"/> PALM BEACH: 561-768-9044
	<input type="checkbox"/> CHICAGO: 312-253-7244	<input type="checkbox"/> EAST TN/TRI-CITIES: 615-425-7427	<input type="checkbox"/> MELBOURNE: 321-800-9515	<input type="checkbox"/> PHILADELPHIA: 844-820-9641
				<input type="checkbox"/> SARASOTA: 941-870-6550
				<input type="checkbox"/> SOUTH JERSEY: 856-519-5309
			<input type="checkbox"/> SOUTHWEST FL: 813-283-9144	
			<input type="checkbox"/> TAMPA: 844-946-0849	
			<input type="checkbox"/> WACO: 254-343-7650	