

Evkeeza® (evinacumab-dgnb) Referral Form



Patient Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status:

New Referral

Updated Referral

Referral Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:	Patient Email:		
NKDA Allergies:	Weight (lbs/kg):	Height:	
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

PROVIDER INFORMATION

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

NURSING

Infusion to be administered per Vivo protocols.

EVKEEZA THERAPY ADMINISTRATION

LABORATORY ORDERS

CBC At each dose Every _____
CMP At each dose Every _____
Other _____ Every _____

15 mg/kg IV every 4 weeks

***Vivo Infusion will perform pregnancy screening prior to every infusion per Vivo policy*

PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 1000 mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25 mg 50 mg PO IV
methylprednisolone (Solu-Medrol) 40mg 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: _____
Dose: _____ Route: _____

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

Cholesterol (including LDL)

****Order is valid for one year unless otherwise noted****

Provider Name (Print)

Provider Signature

Date

Fax Numbers

Colorado: 303-418-4679

Nevada: 702-489-5744

Oklahoma: 918-770-4421

Have a Question? (720) 902-4111

Connecticut: 203-724-4838

New Jersey: 800-540-1852

Pennsylvania: 215-399-9244

Email Referrals To: referrals@vivoinfusion.com

Florida: 904-930-4211

New York: 800-540-1852

Texas: 469-340-0044

Massachusetts: 800-540-1852

Ohio: 216-400-0674

Virginia: 804-500-5941

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