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Phone: 7-800-809-1265 Fax: 1-866-872-8920

MRN:____________________
DOB: ____________________

Standard Plan of Treatment for Evkeeza™ (evinacumab-dgnb)

NOTE: *We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.*

1. **Patient Name**: ____Height (in.):_____ Weight (lbs):_____
2. **Allergies**: ____
3. **Diagnosis:**

☐ Homozygous familial hypercholesterolemia (HoFH) E78.01

☐ Other ICD-10 Code: ________ Description: ________________________________

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4. **Pre-medication:** ***Administered 30 minutes prior to infusion as selected:***

Acetaminophen:	
☐ 1000mg PO ☐ 650mg PO ☐ 500mg PO ☐ 325mg PO	Diphenhydramine: ☐ 25 mg PO ☐ 50 mg PO ☐ 25 mg IV ☐ 50 mg IV *or* Fexofenadine: ☐ 60mg ☐ 180 mg *or* ☐ Cetirizine 10 mg *or* ☐Loratadine 10 mg Methylprednisolone: ☐ 40 mg IV ☐ 125 mg IV or other_______mg IV Famotidine: ☐ 20 mg PO ☐ 40 mg PO ☐ 20 mg IV ☐ 40mg IV

Premedicate with other:____

5. Order:

Evkeeza™ (evinacumab-dgnb) 15mg/kg once monthly (every 4 weeks) via IV infusion over 60 minutes with a 0.2-5 micron filter

Lab orders with infusion: ____

____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

6. Physician's Signature:_______________________/__________________________ **Date**: _____________
(Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:____ NPI: ________________

7. ***Fax updated supporting clinical MD notes with each order renewal or change in orders***

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

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Guidelines for Prescribing Evkeeza™ (evinacumab-dgnb)

(Required documentation with all initial referrals)

Patient Name: ____ **Referral Date:** ___________________

- ☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-7)*
  (Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)
- ☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)
- ☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy.**
- ☐ **Include any lab results and/or tests to support diagnosis:** LDL-C levels (untreated) at time of HoFH diagnosis, LDC-C levels at time initial lipid lowering therapy prescribed, and LDL-C levels under current treatment. History of xanthomas; family history of HeFH or HoFH; patient/family history of CV disease, events, or procedures; family history of high cholesterol > 250
- ☐ Genetic test results if available: Presence of 2 identical (true HoFH) or 2 nonidentical (compound or double HeFH) abnormal LDL-C-raising gene defects
- ☐ Evkeeza™ may cause embryo-fetal harm based on animal studies. **Pregnancy test is recommended prior to initiating treatment in patients who may become pregnant.**
- ☐ Other as requested: ____
  ____

WARNINGS AND PRECAUTIONS

• **Serious Hypersensitivity Reactions**: have occurred with EVKEEZA in clinical trials. If a serious hypersensitivity reaction occurs, discontinue EVKEEZA, treat according to standard-of-care and monitor until signs and symptoms resolve (5.1) • **Embryo-Fetal Toxicity**: EVKEEZA may cause fetal harm based on animal studies. Advise patients who may become pregnant of the risk to a fetus. Consider obtaining a pregnancy test prior to initiating treatment with EVKEEZA. Advise patients who may become pregnant to use contraception during treatment and for at least 5 months following the last dose.

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.