PARAGON HEALTHCARE

A Carelon Company

EVKEEZA INFUSION ORDERS

P: 877.365.5566 | **F:** 855.889.2946

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis:

☐ Familial Hypercholesterolemia (ICD-10 Code: E78.01)

☐ Other: _____ (ICD-10 Code: _____)

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Evkeeza

☐ 15mg/kg IV every 4 weeks x1 year

Lab Orders: _____ **Frequency:** ☐ Every infusion ☐ Other: _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: _____ State: _____ *View our locations here:*

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COMPREHENSIVE SUPPORT FOR EVKEEZA THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ Include patient's medication list
- ☐ Supporting clinical notes (H&P) to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - ☐ Does patient have genetic lab results confirming 2 mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus? ☐ Yes ☐ No
  - ☐ Does patient have an LDL-C > 70 mg/dL despite treatment on maximally tolerated lipid-lowering therapy (e.g, statins, ezetimibe, Repatha) ☐ Yes ☐ No
  - ☐ Does the patient have untreated LDL-C of > 500 mg/dL or treated LDL-C > 300 mg/dL and either of the following: (1) presence of cutaneous or tendinous xanthomas before age of 10 years or (2) untreated LDL-C level of > 190 mg/dL in both parents? ☐ Yes ☐ No
  - ☐ Has the patient been previously treated with lomitapide or lipoprotein apheresis? ☐ Yes ☐ No
- ☐ Labs attached (**LDL-C required**)
- ☐ Other medical necessity: _____

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance