PARAGON HEALTHCARE

A Carelon Company

EVKEEZA (EVINACUMAB) THERAPY INFUSION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:		Gender: ☐ Female ☐ Male	
Address:		City:	State:		ZIP:
Phone:	Email:	Height:	☐ inches ☐ cm	Weight:	☐ lbs. ☐ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: ☐ New to Therapy ☐ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:
Office Contact:			Email:
Address:		City: State:	ZIP:
NPI #:	DEA#:		Tax ID:

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Evkeeza (evinacumab)	☐ 15mg/kg IV every 4 weeks	☐ x 1 year ☐ _____

Other orders: _____

Lab Orders: _____ Lab frequency: ☐ Each infusion ☐ Other: _____
Required labs to be drawn by ☐ Paragon Healthcare ☐ Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. ☐ Dispense as written

PRESCRIBER SIGNATURE

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.

Prescriber Signature: X **Date:**

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COMPREHENSIVE SUPPORT FOR EVKEEZA (EVINACUMAB) THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROSSING & 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: _____