Hy-Vee health

# EVKEEZA
## Order Form

**PHONE** 515.225.2930 | **FAX** 515.559.2495

### Patient Information

☐ **Demographics Attached**

**Patient Name:** _____ **DOB:** _____ **Phone:** _____

**INSURANCE INFORMATION:** Please attach a copy of prescription/medical card(s) (front and back).

### Medical Information

Diagnosis: ☐ Familial hypercholesterolemia ICD-10 Code: E78.01

☐ Other: _____ ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/progress notes, labs and tests supporting primary diagnosis attached

**Labs:** Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

### Evkeeza Orders

☐ 15 mg/kg IV every 4 weeks

**** Once we receive all necessary documentation, we will schedule the patient's treatment.**

### Additional Orders/Comments

### Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

**Physician Signature:** _____ **Physician Name:** _____ **Date:** _____

**Phone:** _____ **Fax:** _____ **Contact Person:** _____

### Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

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