

**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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