

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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