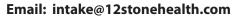
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





EVKEEZA ORDER FORM							
Date:		ICD-10 Code:			Therapy Status		
Patient Name:		Allergies:		New			
Date of Birth:		Weight:Ibs OR _		kg	☐ Continuing Therapy: Last Dose:		
PROVIDER INFORMATION							
Ordering Provider: Provi					Provider Fax:		
Provider NPI:			Provider Address:				
Provider Phone:							
MEDICATION ORDER							
Evkeeza	□ Administer Evkeeza 15mg/ every four weeks.	kg IV over 60 minutes	Refills for one y date of signatur indicated be ———— Re		e unless low.	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion: ✓ LDL within the past six months.	
PRE-MEDICATIONS							
Oral □ Acetaminophen:325mg500mg650mg □ Loratadine: 10mg □ Cetirizine: 10mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Ibuprofen:200mg400mg600mg □ Ondansetron:4mg8mg □ Other:							
LAB ORDERS (please indicate any labs to be drawn and frequency)			OTHER REQUIRED DOCUMENTATION				
Surveillance lab ordering and monitoring is the responsibility of the prescriber By signing below, I certify that the above therapy is medi By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my to payors with respect to this patient and prescription order. This enrollment Dispense as Written:				cally necessary. Prescriber's Signature (SIGN BELOW) y designated agent in submitting prior authorizations and other clinically required information			
Prescriber Name		Proceribor Namo		Data			