TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

AMVUTTRA ORDER FORM

Date:	ICD-10 Code: _____
Patient Name:	Allergies: _____
Date of Birth:	Weight: _____lbs OR _____kg

Therapy Status	Provider Information
☐ New Start	Ordering Provider: _____
☐ Continuing Therapy:	Provider NPI: _____
Last Dose: _____	Provider Phone: _____
	Provider Fax: _____
	Provider Address: _____

MEDICATION ORDER

☐ Amvuttra	✓ Amvuttra 25mg to be given subcutaneously every three months per protocol. ✓ Prescriber has instructed patient to take vitamin A supplementation.	**Refills x one year from date of signature unless indicated below.** ☐ _____ Refills

PRE-MEDICATIONS

Oral	IV
☐ Acetaminophen: ___325mg ___500mg __650mg	☐ Dexamethasone: ___4mg ___8mg
☐ Loratadine: 10 mg	☐ Diphenhydramine: ___25mg __50mg
☐ Cetirizine: 10mg	☐ Famotidine: ___20mg ___40mg
☐ Diphenhydramine: ___25mg ___50mg	☐ Methylprednisolone 125mg
☐ Famotidine: ___20mg ___40mg	☐ Hydrocortisone 100mg
☐ Ibuprofen: ___200mg ___400mg ___600mg	☐ Ondansetron: ___4mg ___8mg
☐ Ondansetron: ___4mg ___8mg	☐ Other_____
☐ Other_____	

LAB ORDERS (Please indicate any labs to be drawn and frequency)	OTHER REQUIRED DOCUMENTATION
	(Please fax this signed order form, along with the following documents to 800-223-4063) • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
Surveillance lab ordering, and monitoring is the responsibility of the prescriber	

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written:	Substitution Allowed:
_____ _____ Prescriber Name Date	_____ _____ Prescriber Name Date