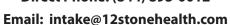
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





AMVUTTRA ORDER FORM					
Date:	ICD-10 Code:	ICD-10 Code:		Therapy Status	
Patient Name:	Allergies:	Allergies:		New Start	
	Weight:Ibs OR _		☐ Continuing Therapy: Last Dose:		
Provider Information					
Ordering Provide	Provider Fax:				
Provider NPI:		Provider Address:			
Provider Phone:					
MEDICATION ORDER					
Amvuttra	 ✓ Amvuttra 25mg to be given subcutaneously every ✓ Prescriber has instructed patient to take vitamin A 			Refills for one year from date of signature unless indicated belowRefills	
PRE-MEDICATIONS					
Oral □ Acetaminophen:325mg500mg650mg □ Loratadine: 10mg □ Cetirizine: 10mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Ibuprofen:200mg400mg600mg □ Ondansetron:4mg8mg □ Other:		IV □ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg □ Ondansetron:4mg8mg □ Other:			
LAB ORDERS					
Surveillance lab ordering and monitoring is the responsibility of the prescriber By signing below, I certify that the above therapy is medically Dispense as Written:		(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 y necessary. Prescriber's Signature (SIGN BELOW) Substitution Allowed:			
Prescriber Name		Prescriber Nan	ne		