**TwelveStone Health Partners**
**Fax Referral To: (615) 278-3355**
**Direct Phone: (844) 893-0012**
**Email: intake@12stonehealth.com**

# ORBACTIV ORDER FORM

Date: _____ ICD-10 Code: _____

Patient Name: _____ Allergies: _____

Date of Birth: _____ Weight: _____ lbs OR _____ kg

**Therapy Status**

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

## PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

## MEDICATION ORDER

| | | | |
|---|---|---|---|
| **Orbactiv** | ✓ infuse 1200mg IV over a minimum of 3 hours x 1 dose | Refills for one year from date of signature unless indicated below.<br>_____ Refills | ***Baseline Labwork Required To Initiate: (check for TwelveStone to draw)***<br>✓ CBC w/ Differential |

## PRE-MEDICATIONS

***Oral***

- ☐ Acetaminophen: _____325mg _____500mg _____650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: _____25mg _____50mg
- ☐ Famotidine: _____20mg _____40mg
- ☐ Ibuprofen: _____ 200mg _____400mg_____600mg
- ☐ Ondansetron: _____4mg _____ 8mg
- ☐ Other: _____

***IV***

- ☐ Dexamethasone: _____4mg _____8mg _____ 10mg
- ☐ Diphenhydramine: _____25mg_____50mg
- ☐ Famotidine: _____20mg_____40mg
- ☐ Methylprednisolone: 125mg
- ☐ Hydrocortisone: 100mg
- ☐ Ondansetron: _____4mg _____8mg
- ☐ Other: _____

## LAB ORDERS (please indicate any labs to be drawn and frequency)

**Surveillance lab ordering and monitoring is the responsibility of the prescriber**

## 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
- Tysabri Touch Enrollment

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

*By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.*

Dispense as Written:

_____ _____
Prescriber Name Date

Substitution Allowed:

_____ _____
Prescriber Name Date