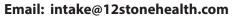
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





for infusion. If no results are available, the following labs will be drawn prior to first infusion: Spevigo If flare symptoms persist, an additional 900mg dose of Spevigo for infusion. If no results are available, the following labs will be drawn prior to first infusion: ✓ Negative TB Quantiferon Gold, or TB Skin T					
Patient Name:	SPEVIGO ORDER FORM				
Patient Name: Allergies:	Date:	ICD-10 Code:			
PROVIDER INFORMATION Ordering Provider: Provider Fax: Provider NPI: Provider Address: Provider Phone: Provider Phone: Provider Address: Provider Phone: Provider Address: Provider Phone: Provider Address: Provider Phone: Provider Address: Provider Address: Provider Address: Provider Phone: Provider Address: Provider Phone: Provider Address: Provider Address: Provider Address: Provider Address: Provider Phone: Provider Address: Provider Phone: Provider Address: Provider Phone: Provider Address: Provider Address: Provider Phone: Provider Phone: Provider Phone: Provider Address: Provider Phone: Provider Phone: Provider Phone: Provider Phone: Provider Phone: Provider Phone:	Patient Name:	Allergies:		_	
Ordering Provider: Provider Fax: Provider NPI: Provider Address: Provider Phone: Provider Phone: Provider Phone: Provider Address: Provider Phone: Provider Address: Provider Address: Provider Phone: Provider Address:	Date of Birth:	Weight:Ibs OR	kg		
Provider NPI:	PROVIDER INFORMATION				
MEDICATION ORDER MEDICATION ORDER Please include the following lab results require for infusion. If no results are available, the following labs will be drawn prior to first infusion: Spevigo If flare symptoms persist, an additional 900mg dose of Spevigo Negative TB Quantiferon Gold, or TB Skin Table Negative TB Qua	Ordering Pr	Provider:	Provider Fax:		
MEDICATION ORDER Please include the following lab results requirements for infusion. If no results are available, the following labs will be drawn prior to first infusion: Spevigo If flare symptoms persist, an additional 900mg dose of Spevigo Vegative TB Quantiferon Gold, or TB Skin To the following labs will be drawn prior to first infusion:	Provider NF	PI:	Provider Address:_		
Please include the following lab results requirements for infusion. If no results are available, the following labs will be drawn prior to first infusion: Spevigo If flare symptoms persist, an additional 900mg dose of Spevigo Please include the following lab results requirements for infusion. If no results are available, the following labs will be drawn prior to first infusion: Negative TB Quantiferon Gold, or TB Skin Table 1.	Provider Phone:				
for infusion. If no results are available, the following labs will be drawn prior to first infusion: Spevigo If flare symptoms persist, an additional 900mg dose of Spevigo for infusion. If no results are available, the following labs will be drawn prior to first infusion: ✓ Negative TB Quantiferon Gold, or TB Skin T	MEDICATION ORDER				
may be administered one week after the initial dose. If warranted, please submit a separate order for this dose.	Spevigo	If flare symptoms persist, an additional 900mg may be administered one week after the initial dos	dose of Spevigose. If warranted,	the following labs will be drawn prior to first infusion:	
PRE-MEDICATIONS					
Oral /V Dexamethasone:4mg8mg □ Loratadine: 10mg □ Diphenhydramine:25mg50mg □ Diphenhydramine:25mg50mg □ Diphenhydramine:25mg50mg □ Methylprednisolone: 125mg □ Famotidine:20mg40mg □ Hydrocortisone: 100mg □ Ibuprofen:200mg400mg600mg □ Ondansetron:4mg8mg □ Other: □ Other:	□ Acetaminophen: 325mg 500mg 650mg □ Loratadine: 10mg □ Cetirizine: 10mg 50mg □ Diphenhydramine: 50mg 50mg □ Famotidine: 40mg 600mg □ Ibuprofen: 4mg 8mg		□ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg □ Ondansetron:4mg8mg		
LAB ORDERS (please indicate any labs to be drawn and frequency) OTHER REQUIRED DOCUMENTATION	LAB ORDERS (please indicate any labs to be drawn and frequency)		OTHER REQUIRED DOCUMENTATION		
(Please fax this signed order form, along with the following document to 800-223-4063) • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List **Surveillance lab ordering and monitoring is the responsibility of the prescriber** **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 informato 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: Substitution Allowed:	By signing below, I certify that the above therapy is med By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as m to payors with respect to this patient and prescription order. This enrollmen		History & Physical, Last Office Visit Note Patient Demographics and Insurance Information Medication List Recent Lab Work ically necessary. Prescriber's Signature (SIGN BELOW) ny designated agent in submitting prior authorizations and other clinically required information int form shall serve as my signature for prior authorizations, as requested.		
Prescriber Signature Date Prescriber Signature Date	· 				