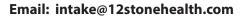
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





SPEVIGO ORDER FORM				
Date:IC				Therapy Status
Patient Name:		Allergies:		☐ New Start
Date of Birth:		Weight:Ibs OR	kg	Continuing Therapy: Last Dose:
PROVIDER INFORMATION				
Ordering Provider:			Provider Fax:	
Provider NPI:			Provider Address:	
Provider Phone:				
MEDICATION ORDER				
Spevigo	□ Administer Spevigo 900mg IV over 90 minutes per protocol.			Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:
	If flare symptoms persist, an additional 900mg dose of Spevior may be administered one week after the initial dose. If warranted please submit a separate order for this dose.			1
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 (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 med By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as re to payors with respect to this patient and prescription order. This enrollment			y designated agent in submitting prior authorizations and other clinically required information	
Prescriber Nam	e	Date	Prescriber Name	 e Date