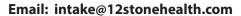
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





VYEPTI ORDER FORM					
Date: ICI			ICD-10 Code: □ C	D-10 Code: G43. Other:	
Patient Name: Alle			Allergies:	ergies:	
Date of Birth: We			Weight: lb	eight: lbs OR kg	
THERAPY STATUS					
☐ New Start ☐ Continuing Therapy:			La	Last Dose:	
PROVIDER INFORMATION					
Ordering Provider:			Provider Fax: _	Provider Fax:	
Provider NPI:			— Provider Addres	Provider Address:	
Provider Phone:					
MEDICATION ORDER					
Vyepti	□ Infuse	mg IV over 30 minutes every 3	months.	Refills for one year from date of signature unless indicated below. Refills	
PRE-MEDICATIONS					
Oral □ Acetaminophen:325mg500mg650mg □ Loratadine: 10mg □ Cetirizine: 10mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Ibuprofen:200mg400mg600mg □ Ondansetron:4mg8mg □ Other:			□ Diphenhyo □ Famotidin □ Methylpre □ Hydrocorti □ Ondanseti	□ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg □ Ondansetron:4mg8mg	
LAB ORDERS (please indicate any labs to be drawn and frequency)			cy) OTH	OTHER REQUIRED DOCUMENTATION	
Surveillance lab ordering and monitoring is the responsibility of the prescriber			to 800-223-406 • History & Phy • Patient Demo • Medication Lis	 (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 	
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:			Substitution Allo	wed:	
Prescriber S	ignature	 Date	Prescriber Sign	ature Date	