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

XERAVA 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

Xerava

☐ Adult Dosage:
Xerava 1mg/kg IV every 12 hours x ________ days per protocol.

☐ Alternative Dosage:
Xerava 1.5mg/kg IV every 24 hours x ________ days per protocol.

☐ Dosage Modification for Hepatic Impairment (Child Pugh C):
Xerava 1mg/kg IV every 12 hourson day 1, followed by Xerava 1mg/kg every 24 hours starting on day 2 for a total of ________ days per protocol.

☐ Dosage Modification in Patients with Concomitant Use of a Strong CYP3A Inducer:
Xerava 1.5mg/kg IV every 12 hours for a total of ________ days per protocol.

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

☐ 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

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 Signature Date

Substitution Allowed:

______________________ ______________
Prescriber Signature Date

V 03.18.25

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