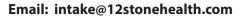
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





XERAVA ORDER FORM				
Date:	ICD-10 Code:		Therapy Status	
Patient Name:	Allergies:		☐ New Start	
Date of Birth:	Weight: lbs OR _	kg	☐ Continuing Therapy: Last Dose:	
PROVIDER INFORMATION				
Ordering Provider: Provider Fax:				
Provider NPI: F		Provider Address:		
Provider Phone:				
MEDICATION ORDER				
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:325mg500mg650mg □ Loratadine: 10mg □ Cetirizine: 10mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Ibuprofen:200mg400mg600mg □ Ondansetron:4mg8mg □ Other:		□ Diphenhy □ Famotidin □ Methylpre □ Hydrocort □ Ondanset □ Other:—		
LAB ORDERS (ple	ease indicate any labs to be drawn and frequency)		HER REQUIRED DOCUMENTATION	
(Please fax this signed order form, along with the following documen 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 Allowed:				
Prescriber Name		Prescriber Nar	me Data	