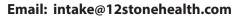
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





ORBACTIV ORDER FORM				
Date:         ICD-10 Code:           Patient Name:         Allergies:           Date of Birth:         Weight:         Ibs OR			☐ New Start ☐ Continuing Thera	Therapy Status apy: Dose:
PROVIDER INFORMATION				
Ordering Provider:  Provider NPI:  Provider Phone:				
MEDICATION ORDER				
Orbactiv   ✓ infuse 1200mg IV over a minimum of 3 hours x 1 dose		Refills for one year from date of signature unless indicated below. Refills		Baseline Labwork Required To Initiate: (check for TwelveStone to draw)  ✓ CBC w/ Differential
PRE-MEDICATIONS				
Oral         □ Acetaminophen:325mg500mg650mg         □ Loratadine: 10mg         □ Cetirizine: 10mg         □ Diphenhydramine:25mg50mg         □ Famotidine:20mg40mg         □ Ibuprofen:200mg400mg600mg         □ Ondansetron:4mg8mg         □ Other:		IV       □ Dexamethasone:4mg8mg10mg         □ 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**		(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  • Tysabri Touch Enrollment		
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 Allo	owed:	Date