

Orbactiv Enrollment Form

TwelveStone Health Partners



Date: _____
 Patient Name: _____
 Date of Birth: _____

Fax Referral To:
(800) 223-4063
 Direct Phone: (615) 278-3350
 Toll Free: (844) 893-0012

PREVIOUS ADMINISTRATION

| | |
|--|--|
| If YES, please provide the following information: | If NO, please indicate desired location for first dose: |
| Last Infusion Date: _____ | <input type="checkbox"/> Physician's Office TwelveStone Infusion Center: <input type="checkbox"/> Canton <input type="checkbox"/> Chattanooga <input type="checkbox"/> Knoxville <input type="checkbox"/> Mount Juliet <input type="checkbox"/> Murfreesboro <input type="checkbox"/> Other: _____ Desired Start Date: _____ |
| Next Infusion Date: _____ | |

DIAGNOSIS

| | |
|---|--|
| Description | ICD-10 Code |
| <input type="checkbox"/> Acute bacterial skin and soft tissue infection <input type="checkbox"/> Other: _____ | <input type="checkbox"/> L08.9 <input type="checkbox"/> Other: _____ |

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

| | |
|---|--|
| <input type="checkbox"/> This signed order form | <input type="checkbox"/> History and Physical |
| <input type="checkbox"/> Patient Demographics and Insurance Information | <input type="checkbox"/> Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis) |
| <input type="checkbox"/> Tysabri Touch Enrollment | |

CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)

Patient Weight: _____ Kg Height: _____ Inches/CM BSA : _____ Allergies: _____

Line Access: PIV PICC (SL DL TL) PORT (Huber size _____ Gauge _____ Length) Sub-Q

| MEDICATION | DIRECTIONS | REFILLS | BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw) |
|-----------------------------------|--|---------|--|
| <input type="checkbox"/> Orbactiv | <input type="checkbox"/> Infuse 1200mg IV over a minimum of 3 hours x 1 dose | | <input type="checkbox"/> CBC w/Differential |

LAB ORDERS - To be drawn by TwelveStone

| Order | Frequency |
|----------------------|---|
| CBC w/Differential | <input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____ |
| CBC w/o Differential | <input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____ |
| CMP | <input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____ |
| BMP | <input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____ |
| CRP | <input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____ |
| Sed Rate | <input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____ |
| Calcium | <input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____ |
| Tb QuantiFERON Gold | <input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____ |
| Hepatitis Panel | <input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____ |
| Other _____ | <input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____ |

PRE-MEDICATIONS/No Pre-meds please check here _____

| <u>Oral</u> | <u>IV</u> |
|---|--|
| Acetaminophen: <input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg | Dexamethasone: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg |
| Cetirizine: <input type="checkbox"/> 10mg | Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg |
| Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg | Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg |
| Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg | Methylprednisolone: <input type="checkbox"/> _____mg IV over _____ mins |
| Ibuprofen: <input type="checkbox"/> 200mg | Ondansetron: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg |
| Loratidine: <input type="checkbox"/> 10mg | |
| Ondansetron: <input type="checkbox"/> 4mg | |

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

| | | | |
|---------------------------|------------------------|----------------------------|---------------------------|
| Physician's Phone # _____ | Physician's NPI# _____ | Physician's Fax # _____ | Physician's Address _____ |
| Dispense as Written _____ | Date _____ | Substitution Allowed _____ | Date _____ |

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