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

RADICAVA ORDER FORM

Date: Patient Name: Date of Birth:	ICD-10 Code: _____ Allergies: _____ Weight: _____lbs OR _____kg

Therapy Status	Provider Information
☐ New Start ☐ Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

MEDICATION ORDER

☐ Radicava	☐ Initial Cycle: Administer Radicava 60mg IV per protocol daily x 14 days followed by a 14-day drug free period. ☐ Maintenance Cycle: Administer Radicava 60mg IV daily for 10 days out of a 14-day period, followed by a 14-day drug free period.	Refills x one year from date of signature unless indicated below. ☐ _____ refills

PRE-MEDICATIONS

Oral	IV
☐ Acetaminophen: ___325mg ___500mg __650mg ☐ Loratadine: 10 mg ☐ Cetirizine: 10mg ☐ Diphenhydramine: ___25mg ___50mg ☐ Famotidine: ___20mg ___40mg ☐ Ibuprofen: ___200mg ___400mg ___600mg ☐ Ondansetron: ___4mg ___8mg ☐ Other_____	☐ 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)	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

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

Dispense as Written: _____ _____ Prescriber Name Date	Substitution Allowed: _____ _____ Prescriber Name Date