TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

XERAVA ORDER FORM

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

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

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 hours on 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	IV
☐ Acetaminophen: ___325mg ___500mg __650mg	☐ Dexamethasone: ___4mg ___8mg
☐ Loratadine: 10 mg	☐ Diphenhydramine: ___25mg __50mg
☐ Cetirizine: 10mg	☐ Famotidine: ___20mg ___40mg
☐ Diphenhydramine: ___25mg ___50mg	☐ Methylprednisolone 125mg
☐ Famotidine: ___20mg ___40mg	☐ Hydrocortisone 100mg
☐ Ibuprofen: ___200mg ___400mg ___600mg	☐ Ondansetron: ___4mg ___8mg
☐ Ondansetron: ___4mg ___8mg	☐ Other_____
☐ 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 above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

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