**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 |

V 9.7.22