Orbactiv Enrollment Form

Date: ______________________
Patient Name: ______________________
Date of Birth: ______________________

TwelveStone Health Partners
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:

Last Infusion Date: ______________________
Next Infusion Date: ______________________

If NO, please indicate desired location for first dose:

☐ Physician's Office
TwelveStone Infusion Center:
☐Canton ☐Chattanooga ☐Knoxville ☐Mount Juliet ☐Murfreesboro
☐ Other: ______________________
Desired Start Date: ______________________

DIAGNOSIS

Description	*ICD-10 Code*
☐ Acute bacterial skin and soft tissue infection ☐ Other:__________________	☐ L08.9 ☐ Other: _______

OTHER REQUIRED DOCUMENTATION *(Please attach documents as needed)*

☐ This signed order form
☐ History and Physical
☐ Patient Demographics and Insurance Information
☐ Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)
☐ Tysabri Touch Enrollment

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

Patient Weight:_________lbs/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)
☐ Orbactiv	☐ Infuse 1200mg IV over a minimum of 3 hours x 1 dose		☐ CBC w/Differential

LAB ORDERS - To be drawn by TwelveStone

Order	Frequency
CBC w/Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
CBC w/o Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
CMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
BMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
CRP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Sed Rate	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Calcium	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Tb QuantiFERON Gold	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Hepatitis Panel	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________
Other__________________________________	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other__________________

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

Oral	IV
Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg	Dexamethasone: ☐ 4mg ☐ 8mg
Cetirizine: ☐ 10mg	Diphenhydramine: ☐ 25mg ☐ 50mg
Diphenhydramine: ☐ 25mg ☐ 50mg	Famotidine: ☐ 20mg ☐ 40mg
Famotidine: ☐ 20mg ☐ 40mg	Methylprednisolone: ☐ _____mg IV over ______ mins
Ibuprofen: ☐ 200mg	Ondansetron: ☐ 4mg ☐ 8mg
Loratidine: ☐ 10mg	
Ondansetron: ☐ 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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