

TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012



SPEVIGO ORDER FORM

Date: _____ ICD-10 Code: _____
 Patient Name: _____ Allergies: _____
 Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status

New Start
 Continuing Therapy: Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____
 Provider NPI: _____ Provider Address: _____
 Provider Phone: _____

MEDICATION ORDER

Spevigo	<input type="checkbox"/> Administer Spevigo 900mg IV over 90 minutes per protocol. <i>If flare symptoms persist, an additional 900mg dose of Spevigo may be administered one week after the initial dose. If warranted, please submit a separate order for this dose.</i>	Refills x one year from date of signature unless indicated below. <input type="checkbox"/> _____ Refills	<p>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</p> <p><input checked="" type="checkbox"/> Negative TB Quantiferon Gold, or TB Skin Test within the last 12 months.</p>
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PRE-MEDICATIONS

<p>Oral</p> <input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<p>IV</p> <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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LAB ORDERS (please indicate any labs to be drawn and frequency)

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 the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:	Substitution Allowed:
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