

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com



PEMGARDA ORDER FORM

Date: _____

ICD-10 Code: _____

Patient Name: _____

Allergies: _____

Date of Birth: _____

Weight: _____ lbs OR _____ kg

Therapy Status

New Start
 Previous Therapy: _____
 Date of Last Dose: _____
 Wash Out Period: _____

Continuing Therapy:
 Last Dose: _____

Provider Information

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

MEDICATION ORDER

Pemgarda

✓ 4500mg IV every 3 months Administered over a minimum of 60 mins.

Refills for one year from date of signature unless indicated below.
 _____ Refills

PRE-MEDICATIONS

Oral

Acetaminophen: _____ 325mg _____ 500mg _____ 650mg
 Loratadine: 10mg
 Cetirizine: 10mg
 Diphenhydramine: _____ 25mg _____ 50mg
 Famotidine: _____ 20mg _____ 40mg
 Ibuprofen: _____ 200mg _____ 400mg _____ 600mg
 Ondansetron: _____ 4mg _____ 8mg
 Other: _____

IV

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 the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)
 By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written:

 Prescriber Name Date

Substitution Allowed:

 Prescriber Name Date