

# TwelveStone Health Partners

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## RADICAVA 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

#### Radicava

- Initial Cycle: Administer Radicava 60mg IV per protocol daily x 14 days followed by a 14-day drug free period.
- Maintenance Cycle: Administer Radicava 60mg IV daily for 10 days out of a 14-day period, followed by a 14-day drug free period.

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

(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:

Substitution Allowed:

\_\_\_\_\_  
Prescriber Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Prescriber Name

\_\_\_\_\_  
Date