

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com



EVKEEZA ORDER FORM

Patient Name: _____	ICD-10 Code: _____	Therapy Status
Date of Birth: _____	Allergies: _____	<input type="checkbox"/> New Start
Weight: _____ lbs OR _____ kg		<input type="checkbox"/> Continuing Therapy: Last Dose: _____

PROVIDER INFORMATION

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

MEDICATION ORDER

Evkeeza	<input type="checkbox"/> Administer Evkeeza 15mg/kg IV over 60 minutes every four weeks.	Refills for one year from date of signature unless indicated below. _____ Refills
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PRE-MEDICATIONS

Oral	IV
<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: _____	<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: _____

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) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work

Surveillance lab ordering and monitoring is the responsibility of the prescriber

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.

Prescriber Signature _____ Date _____