

TwelveStone Health Partners
Fax Referral To: (615) 278-3355 Direct
Phone: (844) 893-0012
Email: referral@12stonehealth.com



LEMTRADA ORDER FORM

Date: _____	ICD-10 Code: _____	Therapy Status
Patient Name: _____	Allergies: _____	☐ New Start
Date of Birth: _____	Weight: _____ lbs OR _____ kg	☐ Continuing Therapy: _____ Last Dose: _____

PROVIDER INFORMATION

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

MEDICATION ORDER

Lemtrada

- ☐ Initiation:
Infuse 12mg IV over 4 hours daily x 5 days
- ☐ Maintenance Dose: (12 months after initial dose)
Infuse 12mg IV over 4 hours daily x 3 days

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:

Substitution Allowed:

Prescriber Signature _____

Date _____

Prescriber Signature _____

Date _____