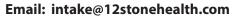
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





REZZAYO ORDER FORM					
Date:		ICD-10 Code:		Therapy Status	
Patient Name:		Allergies:		☐ New Start	
Date of Birth:		Weight:Ibs OR _	kg	☐ Conti	nuing Therapy: Last Dose:
PROVIDER INFORMATION					
Ordering		Provider Fax:			
Provider NPI:			Provider Address:		
Provider Phone:					
MEDICATION ORDER					
Rezzayo	Administer Rezzayo weekly x total doses. Initial dos Rezzayo 400mg IV followed by Rezzayo 200mg IV once weekly thereafter. Rezzayo to be administered over 60 minutes.		e of	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:  ✓ LFTs within the past 60 days	
PRE-MEDICATIONS					
Oral         □ Acetaminophen:325mg500mg650mg         □ Loratadine: 10mg         □ Cetirizine: 10mg         □ Diphenhydramine:25mg50mg         □ Famotidine:20mg40mg         □ Ibuprofen:200mg400mg600mg         □ Ondansetron:4mg8mg         □ 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**					
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 Si	Signature Date Prescriber		Prescriber Sigr	nature	Date