

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com

**ORBACTIV 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**Orbactiv**

✓ Infuse 1200mg IV over a minimum of 3 hours x 1 dose

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 _____ 10mg
☐ 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
- Tysabri Touch Enrollment

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