

**TwelveStone Health Partners**

**Fax Referral To: (615) 278-3355**

**Direct Phone: (844) 893-0012**

**Email: referral@12stonehealth.com**



**IMAAVY ORDER FORM**

Patient Name: _____	ICD-10 Code: _____	<b>Therapy Status</b>
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**

Imaavy	<input type="checkbox"/> Initial Dose: Infuse 30mg/kg IV over 30 minutes x 1 dose  <input type="checkbox"/> Maintenance Dose: Infuse 15mg/kg IV over 15 minutes every 2 weeks (to start 2 weeks after initial dose)	Refills for one year from date of signature unless indicated below.  _____ Refills
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**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

\*\*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