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

GAZYVA ORDER FORM

Patient Name: _____ ICD-10 Code: _____

Date of Birth: _____ Allergies: _____

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

Gazyva	**Active Lupus Nephritis (LN) dosing:** ☐ Initiation: Infuse 1,000mg at initial infusion and on Weeks 2, 24, and 26 ☐ Maintenance: Infuse 1,000mg every 6 months	Refills for one year from date of signature unless indicated below. _____ Refills	*Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:* ✓ Hepatitis B Surface Antigen ✓ Hepatitis B Core Antibody Total (Not Core IgM)

PRE-MEDICATIONS (Per Prescribing Information, Premedicate with Acetaminophen, Antihistamine, and Glucocorticoid)

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)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

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

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

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