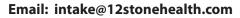
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





KIMYRSA ORDER FORM				
Date: ICD-10 Code:			Therapy Status	
Patient Name:	Allergies:		☐ New Start	
Date of Birth:	Weight:Ibs OR	kg	☐ Continuing Therapy: Last Dose:	
PROVIDER INFORMATION				
Ordering Provider: Provider Fax:				
Provider NPI:				
Provider Phone:				
MEDICATION ORDER				
	MEDICATIO	IN ORDER		
 ✓ Kimyrsa 1,200mg IV x one dose over one hour per protocol. ✓ The use of unfractionated heparin sodium us contraindicated for 120 hours (5 days) after Kimyrsa administration 				
PRE-MEDICATIONS				
Oral □ Acetaminophen:325mg500mg650mg □ Loratadine: 10mg □ Cetirizine: 10mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Ibuprofen:200mg400mg600mg □ Ondansetron:4mg8mg □ Other:		IV □ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg □ 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 medical		(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 cally 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: Prescriber Name	Date	Substitution Allo	lowed:	