Asthma/Allergy Enrollment Form

Date: ____________________

Patient Name: ____________________

Date of Birth: ____________________

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com

DELIVERY AND ADMINISTRATION INFORMATION

Deliver To:

- ☐ Patient's Home
- ☐ MD Office
- ☐ 1st dose to MD office, remaining refills to patient's home

Place of Administration:

- ☐ Physician's Office
- ☐ TwelveStone Infusion Center: ____________________
- ☐ Patient's Home

Previous Treatment: ☐ Naïve ☐ Restart ☐ Continued Therapy:

- ☐ Date of Last Dose: ____________________

DIAGNOSIS

- ☐ D72.110 Idiopathic hypereosinophilic syndrome (IHES)
- ☐ D72.111 Lymphocytic variant hypereosinophilic syndrome (LHES)
- ☐ D72.119 Hypereosinophilic syndrome, unspecified (HES)
- ☐ J33.0 Polyp of the nasal cavity
- ☐ J33.1 Polypoid sinus degeneration
- ☐ J33.8 Other polyp of sinus
- ☐ J33.9 Nasal polyp, unspecified
- ☐ J48.40 Moderate persistent asthma, uncomplicated
- ☐ J45.50 Severe persistent asthma, uncomplicated
- ☐ J45.51 Severe persistent asthma with (acute) exacerbation
- ☐ J82.83 Eosinophilic asthma
- ☐ L20. __________ Moderate to severe atopic dermatitis
- ☐ L50.1 Idiopathic urticaria
- ☐ M30.1 EGPA/Polyarteritis with lung involvement
- ☐ Other: ____________________

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

- ☐ Medical Card (Front & Back)
- ☐ Prescription Card (Front & Back)
- ☐ Patient Demographics
- ☐ Clinic Notes & Labs (CBC w/ diff, IgE, etc.)
- ☐ Pulmonary Function Tests
- ☐ Allergies & Current Medication List
- ☐ Last 4 Digits of Social: ______________
- ☐ Patient Weight __________ kg
- ☐ Patient Height __________ inches

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ **DUPIXENT**	☐ 200mg PFS ☐ 300mg PFS ☐ 200mg Pre-Filled Pen ☐ 300mg Pre-Filled Pen	☐ Inject 400mg (two 200mg injections in different sites) SQ on Day 1, followed by 200mg on Day 15 ☐ Inject 200mg SQ every other week ☐ Inject 600mg (two 300mg injections in different sites) SQ on Day 1, followed by 300mg on Day 15 ☐ Inject 300mg SQ every other week	☐ 28-Day Supply ☐ 84-Day Supply	
☐ **FASENRA**	☐ 30mg PFS, Provider Administered ☐ 30mg AutoInjector, Self-Administerd	☐ Inject 30mg SQ once every 4 weeks for 3 doses ☐ Inject 30mg SQ once every 8 weeks	☐ 28-Day Supply ☐ 84-Day Supply	
☐ **NUCALA**	☐ 100mg Vial, Provider Administered ☐ 100mg PFS, Self-Administerd ☐ 100mg AutoInjector, Self-Administerd	☐ Inject 100mg SQ once every 4 weeks ☐ Inject 300mg (three 100mg injections in different sites) once every 4 weeks	☐ 28-Day Supply ☐ 84-Day Supply	
☐ **TEZSPIRE**	☐ 210mg PFS, Provider Administered	☐ Inject 210mg SQ once every 4 weeks	☐ 28-Day Supply ☐ 84-Day Supply	
☐ **XOLAIR**	☐ 75mg PFS ☐ 150mg PFS ☐ 150mg Vial	☐ Inject __________ mg SQ once every 2 weeks ☐ Inject __________ mg SQ once every 4 weeks	☐ 28-Day Supply ☐ 84-Day Supply	
☐ **EpiPen**	☐ 0.3mg	Use As Directed	☐ 1 Pen	
☐ **EpiPen Jr.**	☐ 0.15mg	Use As Directed	☐ 2-Pak	

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.

Physician's Phone: ______________ Physician's NPI: ______________ Physician's Fax: ______________ Physician's Address: ______________

Dispense As Written: ______________ Printed Name: ______________ Substitution Allowed: ______________ Date: ______________

V 09.03.24 *The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 615-895-0186 or faxing back to the originator.*