TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012



Email: intake@12stonehealth.com

ALPHA-1 ANTITRYPSIN DEFICIENCY ORDER FORM				
Date: ICD-10 Code:			Therapy Status ☐ New Start	
Patient Name: Allergies:				
Date of Birth:	Weight:Ibs OR	kg	☐ Continuing Therapy: Last Dose:	
Provider Information				
Ordering Provider: Provider Fax:				
Provider NPI: Provider Address:				
Provider Phone:				
MEDICATION ORDER				
☐ Alpha-1 Antitryspin Deficiency Agent	✓ 60mg/kg IV to be given weekly	per protocol.		
Therapeutic interchange to insurance preferred medication authorized unless otherwise specified below:	✓ Glassia and Aralast NP: Administer at a rate not to exce 0.2mL/kg/min as determined b patient tolerance.	eed Y	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:
☐ Glassia ☐ Aralast NP	 ✓ Prolastin: Administer at a rate not to exc 0.08mL/kg/min as determined 			
☐ Prolastin (non-preferred agent; please allow 1-2 weeks additional processing time to begin therapy)	patient tolerance. TwelveStone pharmacy to verification individual patient and maintain margin of error on weight-base	fy rate per a +/- 10%		✓ IgA Level
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		 (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.				
Dispense as Written:		Substitution All	owed:	
Prescriber Name	 Date	Prescriber Nam	ne	Date