

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com



CINQAIR ORDER FORM

Date: _____ ICD-10 Code: _____
Patient Name: _____ Allergies: _____
Date of Birth: _____ 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

Cinqair

- Cinqair 3mg/kg IV every four weeks per protocol.
 Cinqair _____ mg/kg IV every _____ weeks per protocol.

Refills for one year from date of signature unless indicated below.

_____ Refills

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.

Dispense as Written:

Substitution Allowed:

Prescriber Name

Date

Prescriber Name

Date