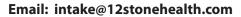
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





	FASENRA OR	RDER FORM	
Date: ICD-10 Code:			Therapy Status
Patient Name: A	llergies:		☐ New Start
Date of Birth:	Veight:Ibs OR	kg	☐ Continuing Therapy: Last Dose:
PROVIDER INFORMATION			
Ordering Provider:		Provider Fax:	
Provider NPI:		Provider Address:	
Provider Phone:			
ADMINISTRATION			
1 _{st} 2 _{nd}	Place of Administr	ration:	
□ □ PFS (Provider- Administered) □ TwelveStone Infus		usion Center	□ Patient's Home
□ □ Autoinjector (Self-Administered) □ MD Office			□ Other
MEDICATION ORDER			
Fasenra Loading Dose: Inject 30mg SQ once every 4 wee Maintenance Dose: Inject 30mg SQ once every 8			Refills for one year from date of signature unless indicated below. Refills
PRE-MEDICATIONS			
Oral □ Acetaminophen:325mg500mg650mg □ Loratadine: 10mg □ Cetirizine: 10mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Ibuprofen:200mg400mg600mg □ 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 medi By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as m to payors with respect to this patient and prescription order. This enrollmen		y designated agent in submitting prior authorizations and other clinically required information	
Dispense as Written:		Substitution Allo	
Prescriber Name	Date	Prescriber Nam	e Date