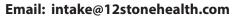
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





| ILARIS ORDER FORM | | | | | | | | |
|--|--|--------------|-----------|---|------------------------------|-----------------------------------|---|--|
| Date: | | ICD-10 Code: | | | | Therapy Status | | |
| Patient Name: | | Allergies: | | | | ☐ New Start | | |
| Date of Birth: | | Weight: | _lbs OR _ | | kg | ☐ Continuing Thera Last | apy: Dose: | |
| PROVIDER INFORMATION | | | | | | | | |
| Ordering Provider: Provider Fax: | | | | | | | | |
| Provider NPI: | | | | Provider Address: | | | | |
| Provider Phone: | | | | | | | | |
| MEDICATION ORDER | | | | | | | | |
| | | | | | | | | |
| | Still's Disease | | | | | | | |
| | □ Ilaris 4mg/kg (maximum dose of 300mg) SQ every 4 wee | | | eks | date of | or one year from signature unless | Please include the following lab results required for infusion. | |
| llaris | Gout Flares | | | | indid | cated below. | If no results are available, the following labs will be drawn | |
| | □ Ilaris 150mg SQ once | | | | | Refills | prior to first infusion: | |
| | Minimum of 12 week interval for subsequent dosing r/t go | | | | | | ✓ TB Quant Gold within the past 12 months | |
| | | | | out | | past 12 month | | |
| DDE MEDICATIONS | | | | | | | | |
| PRE-MEDICATIONS | | | | | | | | |
| Oral | | | | <u>IV</u> | | | | |
| □ Acetaminophen:325mg500mg650mg □ Loratadine: 10mg | | | | □ Diphenhydramine:25mg50mg | | | | |
| ☐ Loratadine: 10mg ☐ Cetirizine: 10mg | | | | □ Famotidine:20mg40mg | | | | |
| □ Diphenhydramine:25mg50mg | | | | ☐ Methylprednisolone: 125mg | | | | |
| □ Famotidine:20mg40mg | | | | ☐ Hydrocortisone: 100mg | | | | |
| □ Ibuprofen: 200mg600mg | | | | □ Ondansetron:4mg8mg | | | | |
| □ Ondansetron:4mg 8mg | | | | □ Other: | | | | |
| □ 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 | | | | |
| **Surveillance lab ordering and monitoring is the responsibility of the prescriber** | | | | 1 | 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: | | | | Subs | Substitution Allowed: | | | |
| | | | | | | | | |
| | | | | | | | | |
| Prescriber Sig | nature | Date | | Pres | criber Sign | nature | | |