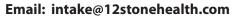
## **TwelveStone Health Partners**

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:	Veight:Ibs OR		kg	☐ Continuing Therapy:  Last Dose:		
PROVIDER INFORMATION								
Ordering Provider:				Provider Fax:				
Provider NPI:				Provider Address:				
Provider Phone:								
MEDICATION ORDER								
	Still's Disease				Refills for one year fron date of signature unless indicated below.			
	□ Ilaris 4mg/kg (maximum dose of 300mg) SQ every 4 weeks						lab results required for infusion.	
llaris	Gout Flares				Indi	Refills	If no results are available, the following labs will be drawn	
	□ Ilaris 150mg SQ once				_		prior to first infusion:	
	Minimum of 12 week interval for subsequent dosing r/t gou						✓ TB Quant Gold within the past 12 months	
				out			pact 12 months	
PRE-MEDICATIONS								
Oral IV								
				□ Dexamethasone:4mg8mg				
□ Loratadine: 10mg				□ Diphenhydramine:25mg50mg				
□ Cetirizine: 10mg				□ Famotidine:20mg40mg				
□ Diphenhydramine:25mg50mg				☐ Methylprednisolone: 125mg				
□ Famotidine:20mg40mg				☐ Hydrocortisone: 100mg				
□ Ibuprofen: 200mg400mg600mg				□ Ondansetron:4mg8mg □ Other:				
□ Ondansetron:4mg8mg					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**				• Re	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	stitution Allo	owed:		
Droscribor No.		Data		- Dres	aribar Nan			