TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com

ILUMYA ORDER FORM

		Therapy Status
Date: _____	ICD-10 Code: _____	☐ New Start
Patient Name: _____	Allergies: _____	☐ Continuing Therapy:
Date of Birth: _____	Weight: _____ lbs OR _____ kg	Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

Provider NPI: _____ Provider Address: _____

Provider Phone: _____

ADMINISTRATION

Place of Administration:

☐ TwelveStone Infusion Center   ☐ MD Office   ☐ Other _____

MEDICATION ORDER

Illumya	☐ Initation: Inject 100mg SQ at weeks 0, and 4. ☐ Maintenance: Inject 100mg SQ every 12 weeks.	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:*** ✓ Negative TB Quantiferon Gold, or TB Skin Test within the last 12 months.

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**
    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 Allowed: _____

_____   _____   _____   _____

Prescriber Name   Date   Prescriber Name   Date

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