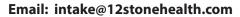
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





RYSTIGGO ORDER FORM						
Date:		ICD-10 Code:		Therapy Status		
Patient Name:		Allergies:				
Date of Birth:		Weight:Ibs OR _	kg		ntinuing Therapy: Last Dose:	
PROVIDER INFORMATION						
Ordering Provider:			Provider Fax:			
Provider NPI:			Provider Address:			
MEDICATION ORDER						
	☐ Weight 50kg to less than 100kg: Infuse 560mg subcutaneously r				Please include the following lab results required for infusion. If no results are available, the following labs will be drawn	
Rystiggo	stiggo Weight 100kg and above: Infuse 840mg subcutaneously weekly for 6 weeks.					
I authorize additional cycles of treatment. Each subsequent cycle will be scheduled 63 days from the start of the previous treatment cycle, unless otherwise specified. The ordering of subsequent cycles of treatment should be based on clinical evaluation.						
PRE-MEDICATIONS						
Oral □ Acetaminophen:325mg500mg650mg □ Loratadine: 10mg □ Cetirizine: 10mg □ Diphenhydramine:25mg50mg			IV □ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg			
□ Famotidine:20mg40mg □ Ibuprofen:200mg400mg600mg □ Ondansetron:4mg8mg □ Other:			☐ Hydrocortisone: 100mg ☐ 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			(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 Alle	owed:		
Prescriber Nam	ne	Date	Prescriber Nan	ne	 Date	