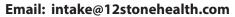
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





	TYENNE O	RDER FORM			
Date: ICD-10 Code:			Therapy Status		
Patient Name:	Allergies:			☐ New Start	
Date of Birth:	Weight:Ibs OR	kg	☐ Continuing Therapy:  Last Dose:		
PROVIDER INFORMATION					
Ordering Provider: Provider Fax:					
		Provider Address:			
Provider Phone:					
		ION ORDER			
Tyenne Therapeutic interchange to insurance preferred biosimilar (Actemra) authorized unless otherwise specified below:	□ Tyenne mg/kg IV every weeks to be given over one hour.  □ (<100kg) Tyenne 162mg SQ to be given every other week.	Refills for one year from date of signature unless indicated below.		Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:   TB Quant Gold within the past 12 months	
□ Do not use biosimilar	□ (≥100kg) Tyenne 162mg SQ to be given weekly.	Re	fills	<ul><li>✓ Hepatitis B Surface Antigen</li><li>✓ Absolute Neutrophil Count, Platelet Count, and ALT/AST within the past 60days</li></ul>	
	PRE-MEI	DICATIONS			
Oral         □ Acetaminophen:325r         □ Loratadine: 10mg         □ Cetirizine: 10mg         □ Diphenhydramine:28         □ Famotidine:20mg         □ Ibuprofen:200mg         □ Ondansetron:4mg         □ Other:	□ Diphenhyd □ Famotidine □ Methylpred □ Hydrocorti □ Ondansetr	□ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg □ Ondansetron:4mg8mg			
LAB ORDERS (please indica	) OTH	OTHER REQUIRED DOCUMENTATION			
By signing this form, I am authorizing Twe	to 800-223-406  • History & Phys • Patient Demog • Medication Lis • Recent Lab W  edically necessary. Is s my designated agent in ment form shall serve as in	(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  ically necessary. Prescriber's Signature (SIGN BELOW)  by designated agent in submitting prior authorizations and other clinically required information and form shall serve as my signature for prior authorizations, as requested.  Substitution Allowed:			
Proscribor Namo	riher Name Data Proscribor N			Dete	