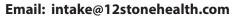
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





UPLIZNA ORDER FORM						
Date:		ICD-10 Code:		Therapy Status  ☐ New Start		
Patient Name:		Allergies:				
Date of Birth:		Weight:Ibs OR		kg	Continuing Therapy:  Last Dose:	
PROVIDER INFORMATION						
Ordering Provider: Provider Fax:						
Provider NPI:			Provider Address:			
Provider Phone:						
MEDICATION ORDER						
	<ul> <li>□ Initiation: Infuse Uplizna 300mg IV on Day 1 and Day 15.</li> <li>□ Maintenance: Infuse 300mg IV every six months. If first maintenance dose, schedule six months from Day 1 of initiation phase.</li> </ul>		efills for one year fro		Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:	
Uplizna			da	ate of signature u indicated belov	nless	<ul><li>✓ Hepatitis B Surface Antigen.</li><li>✓ Hepatitis B Core Antibody Total (Not Core IgM)</li></ul>
	Pre-medications will be given as indicated below unless designated otherwise. Antihistamine dosage and route to be determined by on site provider if not specified.			Refills	5	<ul> <li>✓ Negative TB Quantiferon Gold, or TB Skin Test within the last 12 months.</li> <li>✓ Quantitive Serum Immunoglobulin Screening (Prior to initiation phase of treatment)</li> </ul>
PRE-MEDICATIONS						
Oral         ✓ Acetaminophen:325mg500mgX650mg         □ Loratadine: 10mg         □ Cetirizine: 10mg         ✓ Diphenhydramine:						
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 Allo	wed:		
Proceribor Namo		Dete		Droseriber Nem	_	Data