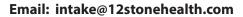
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





XOLAIR ORDER 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:P					er Fax:		
Provider NPI:				Provider Address:			
Provider Phone:							
MEDICATION ORDER							
	✓ Administer mg of Xol every weeks.	mg of Xolair subcutaneously _ weeks.				Per TwelveStone policy, patient must have an Epipen on hand at each appointment. If patient does not have an Epipen, the following will be ordered unless otherwise indicated:	
Xolair	their first three injections of Xolair, followed by a 30 minute observation period for each subsequent injection per policy.			s for one year fron of signature unless idicated below. Refills		Figure 1.3mg autoinjector to be administered SQ or IM to outer thigh as directed in the event of a life-threatening allergic reaction. Dispense: 2 pens Refills: 2 refills	
	□ By checking this box, you indicate that your patient is not subject to an observation period and may exit the facility immediately following injection.					☐ Urticaria Diagnosis Only: By checking this box, you indicate that your patient does not require an Epipen prescription and does not need an Epipen on hand at each appointment.	
PRE-MEDICATIONS							
ORAL □ Acetaminophen:325mg500mg650mg					<u></u>		
□ Loratadine: 10mg				☐ Dexamethasone:4mg8mg			
☐ Cetirizine: 10mg				☐ Diphenhydramine:25mg50mg			
☐ Diphenhydramine:25mg50mg			☐ Famotidine:20mg40mg				
☐ Famotidine:20mg40mg				☐ Methylprednisolone: 125mg ☐ Hydrocortisone: 100mg			
□ Ibuprofen: 200mg 400mg 600mg				☐ Ondansetron:4mg8mg			
□ 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 Deficit Demographics and Insurance Information			
Surveillance lab ordering and monitoring is the responsibility of the prescriber				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:			
Prescribe	r Signature	 Date		Pres	criber Signati	ture Date	