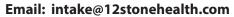
TwelveStone Health Partners

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							
Order		Provider Fax:					
Provider NPI:				Provider Address:			
Provider Phone:							
MEDICATION ORDER							
	remain on-site for a two hour observation following their first three injections of Xolair, followed by a 30 minute observation period for each subsequent injection per policy			s for one year from of signature unless ndicated below. Refills		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							
						☐ 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: 200mg400mg600mg			☐ Ondansetron:4mg8mg				
□ Ondansetron:4mg 8mg			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)			
Surveillance lab ordering and monitoring is the responsibility of the prescriber				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				