

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com



XOLAIR ORDER FORM

Date: _____	ICD-10 Code: _____	Therapy Status
Patient Name: _____	Allergies: _____	<input type="checkbox"/> New Start
Date of Birth: _____	Weight: _____ lbs OR _____ kg	<input type="checkbox"/> Continuing Therapy: Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

MEDICATION ORDER

Xolair	<p><input checked="" type="checkbox"/> Administer _____ mg of Xolair subcutaneously every _____ weeks.</p> <p><input checked="" type="checkbox"/> <i>TwelveStone staff will encourage patients to 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.</i></p> <p><input type="checkbox"/> By checking this box, you indicate that your patient is not subject to an observation period and may exit the facility immediately following injection.</p>	<p>Refills for one year from date of signature unless indicated below.</p> <p style="text-align: center;">_____ Refills</p>	<p><i>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:</i></p> <p><input checked="" type="checkbox"/> Epipen 0.3mg 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</p> <p><input type="checkbox"/> <i>Urticaria Diagnosis Only:</i> <i>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.</i></p>
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PRE-MEDICATIONS

<p>ORAL</p> <p><input type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg _____ 650mg</p> <p><input type="checkbox"/> Loratadine: 10mg</p> <p><input type="checkbox"/> Cetirizine: 10mg</p> <p><input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg</p> <p><input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg</p> <p><input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg</p> <p><input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg</p> <p><input type="checkbox"/> Other: _____</p>	<p>IV</p> <p><input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg</p> <p><input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg</p> <p><input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg</p> <p><input type="checkbox"/> Methylprednisolone: 125mg</p> <p><input type="checkbox"/> Hydrocortisone: 100mg</p> <p><input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg</p> <p><input type="checkbox"/> Other: _____</p>
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LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

<p>**Surveillance lab ordering and monitoring is the responsibility of the prescriber**</p>	<p>(Please fax this signed order form, along with the following documents to 800-223-4063)</p> <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
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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.

<p>Dispense as Written:</p> <p>_____ Prescriber Name</p> <p>_____ Date</p>	<p>Substitution Allowed:</p> <p>_____ Prescriber Name</p> <p>_____ Date</p>
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