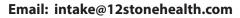
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





KIMYRSA 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: Provider Fax:			
Provider NPI:		Provider Address:	
Provider Phone:			
MEDICATION ORDER			
<ul> <li>✓ Kimyrsa 1,200mg IV x one dose over one hour per protocol.</li> <li>Kimyrsa</li> <li>✓ The use of unfractionated heparin sodium us contraindicated for 120 hours (5 days) after Kimyrsa administration</li> </ul>			
PRE-MEDICATIONS			
Oral         □ Acetaminophen:325mg500mg650mg         □ Loratadine: 10mg         □ Cetirizine: 10mg         □ Diphenhydramine:25mg50mg         □ Famotidine:20mg40mg         □ Ibuprofen:200mg400mg600mg         □ Ondansetron:4mg8mg         □ Other:		IV □ Dexamethasone:4mg8mg   □ Diphenhydramine:25mg50mg   □ Famotidine:20mg40mg   □ Methylprednisolone: 125mg   □ Hydrocortisone: 100mg   □ Ondansetron:4mg8mg   □ Other:	
LAB ORD	<b>DERS</b> (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  • 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 Signature Date		Prescriber Sig	nature Date