

**Rheumatology Medication  
Enrollment Form - Page 1 of 2**

**TwelveStone Health Partners  
Fax Referral To:  
(800) 223-4063**



Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Direct Phone: (615) 278-3350  
Toll Free: (844) 893-0012

**PREVIOUS ADMINISTRATION**

<b>If YES, please provide the following information:</b>	<b>If NO, please indicate desired location for first dose:</b>
Last Infusion Date: _____ Next Infusion Date: _____	<input type="checkbox"/> Physician's Office <input type="checkbox"/> TwelveStone Infusion Suite <input type="checkbox"/> TwelveStone Home Infusion <input type="checkbox"/> Other: _____ Desired Start Date: _____

**DIAGNOSIS**

<b>Description</b>	<b>ICD-10 Code</b>
<input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus Erythematosus <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Gout <input type="checkbox"/> Arthritic Psoriasis	<input type="checkbox"/> M06.9 <input type="checkbox"/> M32.9 <input type="checkbox"/> M45 <input type="checkbox"/> M10 <input type="checkbox"/> L40.5

**OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)**

<input type="checkbox"/> This signed order form	<input type="checkbox"/> History and Physical	<input type="checkbox"/> TB and Hep B Documentation
<input type="checkbox"/> Patient Demographics and Insurance Information	<input type="checkbox"/> Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)	

**CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)**

Patient Weight: \_\_\_\_\_ Kg/Lbs    Height: \_\_\_\_\_ Inches/CM    Allergies: \_\_\_\_\_

Line Access:     PIV     PICC (SL DL TL)     PORT (Huber size \_\_\_\_\_ Gauge \_\_\_\_\_ Length)     Sub-Q

Location:     Hands     Feet     Knees     Spine     Other \_\_\_\_\_

<u>Currently Received and/or Prior Failed Therapies:</u>	<input type="checkbox"/> Biologics: _____ <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Methotrexate <input type="checkbox"/> NSAIDS <input type="checkbox"/> Other: _____ Length of Treatment: _____ Reason for Discontinuing or Adding Supplemental Tx: _____	Contraindicated Medication:  Reason: _____
--	--	--

MEDICATION	DOSE	DIRECTIONS	LAB & ANCILLARY ORDERS	REFILLS
<input type="checkbox"/> Benlysta	<input type="checkbox"/> 120mg Vial	<input type="checkbox"/> Initiation - Infuse 10mg/kg _____ mg IV over 60 minutes at week 0,2, and 4.	<input type="checkbox"/> Baseline Liver Enzymes <input type="checkbox"/> TB Skin Test	
	<input type="checkbox"/> 400mg Vial	<input type="checkbox"/> Maintenance - Infuse 10mg/kg _____ mg IV over 60 minutes every 4 Weeks		
	<input type="checkbox"/> 200mg/ml PFS	<input type="checkbox"/> Inject 200mg SQ once every week		
<input type="checkbox"/> Remicade	100mg Vial	<input type="checkbox"/> Initiation - Infuse 5mg/kg IV over 2-3 hours at week 0,2, and 6.	<input type="checkbox"/> TB Skin Test <input type="checkbox"/> Hepatitis B protocol	
		<input type="checkbox"/> Maintenance - Infuse 5mg/kg IV over 2-3 hours every 8 weeks		
<input type="checkbox"/> Inflectra	100mg Vial	<input type="checkbox"/> Initiation - Infuse 5mg/kg IV over 2-3 hours at week 0,2, and 6.	<input type="checkbox"/> TB Skin Test <input type="checkbox"/> Hepatitis B protocol	
		<input type="checkbox"/> Maintenance - Infuse 5mg/kg IV over 2-3 hours every 8 weeks		
<input type="checkbox"/> Renflexis	100mg Vial	<input type="checkbox"/> Initiation - Infuse 5mg/kg IV over 2-3 hours at week 0,2, and 6.	<input type="checkbox"/> TB Skin Test <input type="checkbox"/> Hepatitis B protocol	
		<input type="checkbox"/> Maintenance - Infuse 5mg/kg IV over 2-3 hours every 8 weeks		
<input type="checkbox"/> Humira	<input type="checkbox"/> 40mg Pen	<input type="checkbox"/> Initiation - 1st dose inject 160mg SQ, then 2 weeks later inject 80mg SQ	<input type="checkbox"/> TB Skin Test <input type="checkbox"/> Baseline CBC and q _____ thereafter	
	<input type="checkbox"/> 80mg Pen	<input type="checkbox"/> Maintenance - Inject 40mg SQ every other week		
<input type="checkbox"/> Cimzia	200mg/ml PFS	<input type="checkbox"/> Initiation - Inject 2ml (400mg - 2 syringes) SQ at weeks 0,2, and 4.	<input type="checkbox"/> TB Skin Test	
		<input type="checkbox"/> Maintenance - Inject 2ml (400mg - 2 syringes) SQ every 4 weeks		
<input type="checkbox"/> Stelara	<input type="checkbox"/> 130mg vial	<input type="checkbox"/> Initiation - < 55kg 260mg; 55-85kg 390mg; > 85kg 520mg IV infusion over 60 minutes x 1 dose	<input type="checkbox"/> TB Skin Test	
	<input type="checkbox"/> 90mg PFS	<input type="checkbox"/> Maintenance - Inject 90mg SQ every 8 weeks		

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 615-895-0186 or faxing back to the originator.

**Rheumatology Medication Enrollment Form - Page 2 of 2**

**TwelveStone Health Partners**

**Fax Referral To:**

**(800) 223-4063**



Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

MEDICATION	DOSE	DIRECTIONS	LAB & ANCILLARY ORDERS	REFILLS
<input type="checkbox"/> Orencia	<input type="checkbox"/> 250mg Vial	<input type="checkbox"/> Initiation - Infuse _____mg IV over 30 minutes at week 0, 2, and 4.	<input type="checkbox"/> CBC with Differential	
	<input type="checkbox"/> 50mg/0.4ml PFS	<input type="checkbox"/> Maintenance - Infuse _____mg IV over 30 minutes every 4 weeks.		
	<input type="checkbox"/> 87.5mg/0.7ml PFS	<input type="checkbox"/> Maintenance - Inject _____mg SQ every week		
	<input type="checkbox"/> 125mg/ml PFS			
<input type="checkbox"/> Simponi	50mg/4ml	<input type="checkbox"/> Initiation - Infuse 2mg/kg _____mg IV over 30 minutes at week 0 and 4	<input type="checkbox"/> TB Skin Test <input type="checkbox"/> CBC with Differential	
		<input type="checkbox"/> Maintenance - Infuse 2mg/kg _____mg IV over 30 minutes every 8 Weeks		
<input type="checkbox"/> Cosentyx	<input type="checkbox"/> 150mg/ml Pen	<input type="checkbox"/> Initiation - 150mg or 300mg SQ at 0,1,2,3, and 4 weeks		
	<input type="checkbox"/> 150mg/ml PFS	<input type="checkbox"/> Maintenance - 150mg or 300mg SQ every 4 weeks		
<input type="checkbox"/> Actemra	<input type="checkbox"/> 162mg/0.9ml	<input type="checkbox"/> Initiation - Inject 162mg SQ every other week		
		<input type="checkbox"/> Maintenance - Inject 162mg SQ every week		
	<input type="checkbox"/> 20mg/ml vial	<input type="checkbox"/> Initiation - Infuse _____mg IV over 60 minutes every ____ weeks		
		<input type="checkbox"/> Maintenance - Infuse _____mg IV over 60 minutes every ____ weeks		
<input type="checkbox"/> Enbrel	<input type="checkbox"/> 25mg/ml PFS	<input type="checkbox"/> Inject 50mg SQ once weekly		
	<input type="checkbox"/> 50mg/ml Autoinject	<input type="checkbox"/> Inject 50mg SQ twice weekly x 3 months, then 50mg once weekly thereafter		
<input type="checkbox"/> Krystexxa	8mg/ml Vial	Infuse 8mg IV over 2 hours every 2 weeks		
<input type="checkbox"/> Rituxan	10mg/ml (100ml, 500ml)	<input type="checkbox"/> Infuse 1000mg IV at increments of 50mg/hr every 30 minutes to a max rate of 400mg/hr x 2 doses separated by 2 weeks. <input type="checkbox"/> Premedicate 30 minutes prior with Methylprednisolone 100mg IV over 15 minutes.	<input type="checkbox"/> CBC with Differential	
<input type="checkbox"/> Otezla	<input type="checkbox"/> Starter Pack	<input type="checkbox"/> Initiation - Titrate dose up to 30mg PO BID starting with 10mg qAM		
	<input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> Maintenance - Take 1 (one) tablet my mouth twice daily		
<input type="checkbox"/> Xeljanz	<input type="checkbox"/> Xeljanz 5mg	<input type="checkbox"/> Take one tablet by mouth twice daily		
	<input type="checkbox"/> Xeljanz XR 11mg	<input type="checkbox"/> Take one tablet by mouth daily		
<input type="checkbox"/> Kineret	100mg/0.67ml PFS	Inject 100mg SQ every day		
<input type="checkbox"/> Zoledronic Acid	5mg Vial	Infuse 5mg IV continuous Infusion over 15 minutes every ____ year(s).		
<input type="checkbox"/> Kevzara	<input type="checkbox"/> 150mg/1.14ml	<input type="checkbox"/> Reduce Injection to 150mg SQ every 2 weeks to manage neutropenia, or thrombocytopenia	<input type="checkbox"/> CBC with Differential	
	<input type="checkbox"/> 200mg/1.14ml	<input type="checkbox"/> Inject 200mg SQ every 2 weeks		

**Premedication(s):**

- Diphenhydramine 25-50 mg po – 25mg #2 per dose
- Acetaminophen 325-650 mg po – 325mg #2 per dose
- Methylprednisolone \_\_\_\_\_mg IV over \_\_\_\_\_mins
- Other: \_\_\_\_\_

**Ancillary Orders:**

- NaCl 0.9% 5-10ml IV before and after infusion
  - Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN
  - Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN
  - All infusion supplies necessary to administer the medication
- Anaphylaxis Kit

**By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers.

Dispense as Written

Date

Substitution Allowed

Date

*The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 615-895-0186 or faxing back to the originator.*