Dermatology
Enrollment Form – Page 1 of 2

Date: _____
Patient Name: _____
Date of Birth: _____

TwelveStone Health Partners
Fax Referral To:
(800) 223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

PREVIOUS ADMINISTRATION

If YES, please provide the following information:

Last Infusion Date: _____
Next Infusion Date: _____

If NO, please indicate desired location for first dose:

☐ Physician's Office
☐ TwelveStone Infusion Suite
☐ TwelveStone Home Infusion
☐ Other:
Desired Start Date: _____

DIAGNOSIS

Description	*ICD-10Code*

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

☐ This signed order form ☐ History and Physical ☐ TB and Hep B Documentation
☐ Patient Demographics and Insurance Information ☐ 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 BSA: _____ Allergies: _____

Line Access: ☐ PIV ☐ PICC (SL DL TL) ☐ PORT (Huber size____Gauge____Length) ☐ Sub-Q

CURRENTLY RECEIVING AND/OR PRIOR FAILED THERAPIES:

☐ Biologics: ☐ Cimzia ☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Orencia ☐ Remicade ☐ Rituxan ☐ Simponi ☐ Stelara
☐ Methotrexate ☐ Soriatane ☐ CYA ☐ PUVA/UVB ☐ Topicals ☐ Other _____

Length of Treatment _____
Reason for Discontinuing or Adding Supplemental Tx: _____
Contradicted Medications: _____
Reason: _____

MEDICATION			REFILLS	LAB & ANCILLARY ORDERS
☐ Cosentyx	☐ 150mg/ml Pen	☐ Initiation - Inject 300mg SQ at 0,1,2,3,4 and then every 4 weeks thereafter	0	
	☐ 150mg/ml PFS	☐ Maintenance - Inject 300mg SQ every 4 weeks		
☐ Humira	☐ 40mg Pen	☐ Initiation - Inject 80mg SQ followed by 40mg every other week starting 1 week after initial dose	0	
	☐ 80mg Pen	☐ Maintenance - Inject 300mg SQ every 4 weeks		
☐ Tremfya	100mg/ml PFS	☐ Initiation - 100mg SQ at 0, 4 weeks, and then every 8 weeks thereafter.	0	
		☐ Maintenance - Inject 100mg SQ every 8 weeks		
☐ Stelara	☐ 45mg PFS	☐ Initiation (< 100kg) – Inject 45mg SQ week 0, and 4, then 45mg every 12 weeks thereafter	0	
		☐ Maintenance (<100kg) - Inject 45mg SQ every 12 weeks		
	☐ 90 mg PFS	☐ Initiation (> 100kg) – Inject 90mg SQ week 0, and 4, then 90mg every 12 weeks thereafter		
		☐ Maintenance (> 100kg) - Inject 90mg every 12 weeks		
☐ Dupixent	300mg/2ml PFS	☐ Initiation - Inject 600mg SQ day 1, then 300mg on day 15, then 300mg every other week	0	
		☐ Maintenance - Inject 300mg SQ every other week		
☐ Odomzo	200mg Capsule	Take 1 (one) capsule by mouth daily on an empty stomach	0	
☐ Otrexup		Inject _____ mg SQ weekly (10-25mg usual dose)	0	
☐ Otezla	☐ Starter Pack	☐ Initiation - Titrate dose up to 30mg PO BID starting with 10mg qAM	0	
	☐ 30mg Tablets	☐ Maintenance - Take 1 (one) tablet my mouth twice daily		
☐ Cimzia	200mg/ml PFS	☐ Initiation - Inject 400mg SQ (2 injections) at weeks 0,2,and 4	0	
		☐ Maintenance - Inject 200mg SQ every other week		
		☐ Alternate Maintenance - Inject 400mg SQ (2 injections) every other week		

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MEDICATION	DOSE	DIRECTIONS	REFILLS	LAB & ANCILLARY ORDERS
☐ Siliq	210mg PFS	☐ Initiation - 210mg SQ at 0,1,2 weeks, and then every 2 weeks thereafter ☐ Maintenance - Inject 210mg SQ every 2 weeks	0	
☐ Remicade		☐ Initiation - Inject ____ mg IV infusion at 0,2,6 weeks and then every 8 weeks thereafter (5mg/kg) ☐ Maintenance - Infuse ____ mg IV every 8 weeks (5mg/kg)	0	
☐ Rasuvo		Inject _____ mg SQ weekly (7.5-30mg usual dose)	0	
☐ Enbrel	☐ Sureclick 50mg/ml ☐ 25mg/ml PFS ☐ 50mg/ml PFS	☐ Initiation - Inject 50mg SQ twice weekly x 3 months; then 50mg weekly thereafter (adult dosing) ☐ Maintenance - Inject 50mg SQ weekly ☐ Maintenance - Inject 0.8mg/kg (_____mg) SQ once weekly (Pediatric dosing)	0	
☐ Simponi Aria	50mg/4ml	☐ Initiation – Infuse 2mg/kg (_____mg) IV over 30 minutes at week 0, week 4, and week 8 ☐ Maintenance – Infuse 2mg/kg (_____mg) IV over 30 minutes every 8 weeks	0	☐ TB Skin Test ☐ CBC w/Diff q_____
☐ Simponi	☐ 50mg/0.5ml Smartject ☐ 50mg/0.5ml PFS	Inject 50mg SQ once monthly	0	☐ TB Skin Test ☐ CBC w/Diff q_____
☐ Erivedge	150mg Capsules	Take 1 (one) capsule by mouth daily	0	
☐ Inflectra		☐ Initiation - Inject ____ mg IV infusion at 0,2,6 weeks and then every 8 weeks thereafter (5mg/kg) ☐ Maintenance - Infuse ____ mg IV every 8 weeks (5mg/kg)	0	
☐ Renflexis		☐ Initiation - Inject ____ mg IV infusion at 0,2,6 weeks and then every 8 weeks thereafter (5mg/kg) ☐ Maintenance - Infuse ____ mg IV every 8 weeks (5mg/kg)	0	

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:

IV Access Flush Order:

- ☐ NaCl 0.9% 5-lOml 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.

_____	_____	_____	_____
Physician's Phone#	Physician's NPI#	Physician's Fax	Physician's Address
_____	_____	_____	_____
Dispense as Written	Printed Name	Substitution Allowed	Date