# Rheumatology Medication 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: | If NO, please indicate desired location for first dose: |
|---|---|
| Last Infusion Date: _____<br>Next Infusion Date: _____ | ☐ Physician's Office<br>☐ TwelveStone Infusion Suite<br>☐ TwelveStone Home Infusion<br>☐ Other: _____<br>Desired Start Date: _____ |

## DIAGNOSIS

| *Description* | *ICD-10 Code* |
|---|---|
| ☐ Rheumatoid Arthritis ☐ Lupus Erythematosus ☐ Ankylosing Spondylitis<br>☐ Gout ☐ Arthritic Psoriasis | ☐ M06.9 ☐ M32.9 ☐ M45<br>☐ M10 ☐ L40.5 |

## 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 Allergies: _____

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

Location: ☐ Hands ☐ Feet ☐ Knees ☐ Spine ☐ Other _____

| Currently Received and/or Prior Failed Therapies: | Contraindicated Medication: |
|---|---|
| ☐ Biologics: _____<br>☐ Corticosteroids ☐ Methotrexate ☐ NSAIDS ☐ Other: _____<br>Length of Treatment: _____<br>Reason for Discontinuing or Adding Supplmental Tx:_____ | Reason: |

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

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|---|---|---|---|---|
| ☐ Orencia | ☐ 250mg Vial | ☐ Initiation - Infuse _____mg IV over 30 minutes at week 0, 2, and 4. | ☐ CBC with Differential | 0 |
| | ☐ 50mg/0.4ml PFS | ☐ Maintenance - Infuse _____mg IV over 30 minutes every 4 weeks. | | 0 |
| | ☐ 87.5mg/0.7ml PFS | ☐ Maintenance - Inject _____mg SQ every week | | 0 |
| | ☐ 125mg/ml PFS | | | |
| ☐ Simponi | ☐ 50mg/4ml | ☐ Initiation - Infuse 2mg/kg _____mg IV over 30 minutes at week 0 and 4 | ☐ TB Skin Test<br>☐ CBC with Differential | 0 |
| | | ☐ Maintenance - Infuse 2mg/kg _____ mg IV over 30 minutes every 8 Weeks | | 0 |
| ☐ Cosentyx | ☐ 150mg/ml Pen | ☐ Initiation - 150mg or 300mg SQ at 0,1,2,3, and 4 weeks | | 0 |
| | ☐ 150mg/ml PFS | ☐ Maintenance - 150mg or 300mg SQ every 4 weeks | | 0 |
| ☐ Actemra | ☐ 162mg/0.9ml | ☐ Initiation - Inject 162mg SQ every other week | | 0 |
| | | ☐ Maintenance - Inject 162mg SQ every week | | |
| | ☐ 20mg/ml vial | ☐ Initiation - Infuse _____mg IV over 60 minutes every ___ weeks | | 0 |
| | | ☐ Maintenance - Infuse _____mg IV over 60 minutes every ___ weeks | | |
| ☐ Enbrel | ☐ 25mg/ml PFS | ☐ Inject 50mg SQ once weekly | | 0 |
| | ☐ 50mg/ml Autoinject | ☐ Inject 50mg SQ twice weekly x 3 months, then 50mg once weekly thereafter | | 0 |
| ☐ Krystexxa | 8mg/ml Vial | Infuse 8mg IV over 2 hours every 2 weeks | | 0 |
| ☐ Rituxan | 10mg/ml (100ml, 500ml) | ☐ 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.<br>☐ Premedicate 30 minutes prior with Methylprednisolone 100mg IV over 15 minutes. | ☐ CBC with Differential | 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 | | 0 |
| ☐ Xeljanz | ☐ Xeljanz 5mg | ☐ Take one tablet by mouth twice daily | | 0 |
| | ☐ Xeljanz XR 11mg | ☐ Take one tablet by mouth daily | | 0 |
| ☐ Kineret | 100mg/0.67ml PFS | Inject 100mg SQ every day | | 0 |
| ☐ Zoledronic Acid | 5mg Vial | Infuse 5mg IV continuous Infusion over 15 minutes every ____ year(s). | | 0 |
| ☐ Kevzara | ☐ 150mg/1.14ml | ☐ Reduce Injection to 150mg SQ every 2 weeks to manage neutropenia, or thrombocytopenia | ☐ CBC with Differential | 0 |
| | ☐ 200mg/1.14ml | ☐ Inject 200mg SQ every 2 weeks | | 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: _____

**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.**

| Physician's Phone# | Physician's NPI# | Physician's Fax# | Physician's Address |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

| Dispense as Written | Date | Substitution Allowed | Date |
|---|---|---|---|
| _____ | _____ | _____ | _____ |