Neurology Enrollment Form

Date: ______________________

Patient Name: ______________________

Date of Birth: ______________________

Diagnosis Date: ______________________

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

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

PREVIOUS ADMINISTRATION OF PRESCRIBED THERAPY

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
- ☐ Enroll in Manufacturer Nurse Training

Desired Start Date: ______________________

DIAGNOSIS

Description

Primary: ______________________

Other/Supporting Diagnosis: ______________________

ICD-10 Code

- ☐ __________
- ☐ Other ICD 10: _________

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

- ☐ This signed order form
- ☐ History and Physical
- ☐ Tysabri Touch Authorization
- ☐ 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

MEDICATION	DOSE	DIRECTIONS	LAB & ANCILLARY ORDERS	REFILLS
☐ Tysabri	300mg	Infuse intravenously over 1 hour every 4 weeks	Liver Function Tests q ___	
☐ Lemtrada	12mg	☐ 1st Course - infuse intravenously over 4 hours daily x 5 days ☐ 2nd Course - infuse intravenously over 4 hours daily x 3 days	Thyroid Fxn Tests – q 3 months CBC with Diff monthly x 48 months	
☐ Ocrevus	600mg	☐ Start - infuse intravenously over 2.5 hours 300mg week 0, then 300mg week 2 ☐ Maintenance - Infuse 600mg over 3.5 hours every 6 months		
☐ Onpattro	10mg/5ml vial	<100kg - Infuse _____mg (0.3mg/kg) IV over 80 minutes every 3 weeks 100kg or > - Infuse 30mg IV over 80 minutes every 3 weeks	Pre-medicate with corticosteroid, acetaminophen and antihistamine	
☐ Soliris	300mg/30ml vial	☐ Initiation - Infuse _____mg IV weekly over 35 minutes x ___ doses, then _____mg 7 days later, then _____mg every 2 weeks thereafter ☐ Maintenance - Infuse _____mg IV every 2 weeks over 35 minutes	Confirm Meningococcal vaccination	
☐ Rituxan	100mg/10ml	Infuse ______ mg IV Infusion over _______ minutes daily	CBC with Diff q _____	
☐ Solu-Medrol	1Gm Vial	Infuse ______ mg IV Infusion over _______ minutes daily		

MEDICATION	DOSE	LAB ORDERS & ADDITIONAL INSTRUCTIONS
Intravenous ☐ Bivigam® ☐ Gammagard® S/D ☐ Gammagard® Liq. 10% ☐ Gammaked® 10% ☐ Gammaplex® 5% ☐ Gamunex - C® 10% ☐ Privigen® 10% ☐ Panzyga® _______% ☐ Other _____________	Order__________Gms/day x__________days; OR ___________Gms/Kg divide over_______days ***Frequency***: every_____weeks, or_____one time dose ***Duration***: ☐ 1month ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other	

MEDICATION	DOSE	LAB ORDERS & ADDITIONAL INSTRUCTIONS
Subcutaneous ☐ Gammagard® Liq. 10% ☐ Gammaked® 10% ☐ Gamunex - C® 10% ☐ Hizentra® 10% ☐ Hizentra® 20% ☐ Cuvitru® 20% ☐ Other	Order__________Gms ***Frequency***: every_____week(s) ***Duration***: ☐ 1month ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other	

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-l0ml 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

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.