

**Pulmonary/Allergy Therapy
Enrollment Form**

TwelveStone Health Partners

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

**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 Center
- TwelveStone Home Infusion
- Enroll in Manufacturer Nurse Training
- Desired Start Date: _____

DIAGNOSIS

Description

- Asthma
- Eosinophilic Granulomatosis with Polyangiitis
- Cystic Fibrosis
- Pseudomonas Aeruginosa
- Pulmonary Arterial Hypertension
- Other/Supporting Diagnosis: _____

ICD-10Code

- J45.909
- D72.1
- L50.1
- E84.0
- B96.5
- Other ICD 10: _____

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

MEDICATION	DOSE	DIRECTIONS	LAB & ANCILLARY ORDERS	REFILLS
<input type="checkbox"/> Cinqair	100mg/10ml Vial	Infuse 3mg/kg every 4 weeks by intravenous infusion over 20-50 minutes	CBC with Diff q _____	
<input type="checkbox"/> Nucala	<input type="checkbox"/> 100mg Vial	<input type="checkbox"/> Asthma – Inject 100mg SQ once every 4 weeks	CBC with Diff q _____	
	<input type="checkbox"/> 100mg PFS	<input type="checkbox"/> EGPA – Inject 300mg SQ once every 4 weeks		
<input type="checkbox"/> Xolair	150mg Vial	Asthma – Inject _____ (75 to 300mg) SQ once every 2 or 4 weeks		
<input type="checkbox"/> Fasenna	30mg PFS	<input type="checkbox"/> Initiation – Inject 30mg SQ once every 4 weeks for 3 doses	CBC with Diff q _____	
		<input type="checkbox"/> Maintenance – Inject 30mg SQ once every 8 weeks		
<input type="checkbox"/> Kitabis	300mg/5ml Ampules	Inhale 5mls (300mg) via jet nebulizer/compressor system twice daily x 28 days, then off x 28 days	Scr/BUN q _____	
<input type="checkbox"/> Cayston	75mg Vial	Inhale 1ml (75mg) via Altera Nebulizer 3 times daily x 28 days		
<input type="checkbox"/> Tobramycin	300mg/5ml Ampules	Inhale 5mls (300mg) via jet nebulizer/compressor system twice daily x 28 days, then off x 28 days	Scr/BUN q _____	
<input type="checkbox"/> Pulmozyme	2.5mg/2.5ml Ampule	Inhale 2.5mg (2.5ml) via jet nebulizer/compressor system QD or BID		
<input type="checkbox"/> Botox	<input type="checkbox"/> 100mg unit vial	Inject _____ units _____ IM or _____ ID into the _____ as directed		
	<input type="checkbox"/> 200mg unit vial			
<input type="checkbox"/> Dupixent	<input type="checkbox"/> 200mg PFS	<input type="checkbox"/> Inject 400mg (2x 200mg) SQ followed by 200mg SQ every other week		
	<input type="checkbox"/> 300mg PFS	<input type="checkbox"/> Inject 600mg (2x 300mg) SQ followed by 300mg SQ every other week		

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)

 Physician's Phone Physician's NPI# Physician's Fax# Physician's Address

 Dispense as Written Printed Name Substitution Allowed Date

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