Xolair Enrollment Form

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 Injection Date: _____ Next Injection Date: _____	☐ Physician's Office TwelveStone Infusion Center: ☐Canton ☐Chattanooga ☐Knoxville ☐Mount Juliet ☐Murfreesboro ☐ Other: _____ Desired Start Date: _____

DIAGNOSIS

Description	*ICD-10 Code*
☐ Asthma ☐ Chronic Idiopathic Urticaria	☐ J45.900 ☐ L50.1

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

☐ This signed order form	☐ History and Physical
☐ 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 Height: _____Inches/CM BSA :_____ Allergies: _____

MEDICATION	DOSE	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw)
☐ Xolair	☐ 150mg Vial (will use unless training for home administration) ☐ 150mg/ml PFS ☐ 75mg/0.5ml PFS	☐ Asthma - Inject _____ mg SQ every _____ weeks. ☐ Urticaria - Inject _____ mg SQ every 4 weeks		☐ Serum IgE level ___x 1 to determine appropriate dosing; Re-test for interruptions in treatment > 1 year

LAB ORDERS - To be drawn by TwelveStone

Order	Frequency
CBC w/Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
CBC w/o Differential	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
CMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
BMP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
CRP	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Sed Rate	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Calcium	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Tb QuantiFERON Gold	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Hepatitis Panel	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____
Other_____	☐ One Time Prior to Treatment ☐ Every Treatment ☐ Q ____Weeks ☐ Other_____

PRE-MEDICATIONS - *Required/If No Pre-Meds ordered please check here_____

Oral	IV
Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg	Dexamethasone: ☐ 4mg ☐ 8mg
Cetirizine: ☐ 10mg	Diphenhydramine: ☐ 25mg ☐ 50mg
Diphenhydramine: ☐ 25mg ☐ 50mg	Famotidine: ☐ 20mg ☐ 40mg
Famotidine: ☐ 20mg ☐ 40mg	Methylprednisolone: ☐ _____mg IV over _____ mins
Ibuprofen: ☐ 200mg	Ondansetron: ☐ 4mg ☐ 8mg
Loratidine: ☐ 10mg	**SQ/IM**
Ondansetron: ☐ 4mg	*EpiPen: Use as directed ☐ x1 Pen

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	Date	Substitution Allowed	Date