Pulmonary/Allergy Therapy 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

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
☐ Cinqair	100mg/10ml Vial	Infuse 3mg/kg every 4 weeks by intravenous infusion over 20-50 minutes	CBC with Diff q _____	
☐ Nucala	☐ 100mg Vial	☐ Asthma – Inject 100mg SQ once every 4 weeks	CBC with Diff q ______	
	☐ 100mg PFS	☐ EGPA – Inject 300mg SQ once every 4 weeks		
☐ Xolair	☐ 150mg Vial	☐ Asthma – Inject ______ mg SQ once every ______ weeks		
	☐ 75mg/0.5ml PFS	☐ Urticaria – Inject ______ mg SQ once every 4 weeks		
	☐ 150mg/ml PFS			
☐ Fasenra	☐ 30mg PFS	☐ Initiation – Inject 30mg SQ once every 4 weeks for 3 doses	CBC with Diff q ______	
	☐ 30mg/ml Autoinjector	☐ Maintenance – Inject 30mg SQ once every 8 weeks		
☐ 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 ______	
☐ Cayston	75mg Vial	Inhale 1ml (75mg) via Altera Nebulizer 3 times daily x 28 days		
☐ 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 ______	
☐ Pulmozyme	2.5mg/2.5ml Ampule	Inhale 2.5mg (2.5ml) via jet nebulizer/compressor system QD or BID		
☐ Botox	☐ 100mg unit vial	Inject ______ units ______ IM or ______ID into the ______________________as directed		
	☐ 200mg unit vial			
☐ Dupixent	☐ 200mg PFS	☐ Inject 400mg (2x 200mg) SQ followed by 200mg SQ every other week		
	☐ 300mg PFS	☐ 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-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)

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

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