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: ______________________ Next Infusion Date: ______________________	☐ Physician's Office ☐ TwelveStone Infusion Suite ☐ TwelveStone Home Infusion ☐ Other: ______________________ Desired Start Date: ______________________

DIAGNOSIS

Description	*ICD-10 Code*
☐ Rheumatoid Arthritis ☐ Lupus Erythematosus ☐ Ankylosing Spondylitis ☐ Gout ☐ Arthritic Psoriasis	☐ M06.9 ☐ M32.9 ☐ M45 ☐ 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:	☐ Biologics: ______________________ ☐ Corticosteroids ☐ Methotrexate ☐ NSAIDS ☐ Other: ______________ Length of Treatment: ______________________ Reason for Discontinuing or Adding Supplmental Tx:______________	Contraindicated Medication: ______________ 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 ☐ TB Skin Test	
	☐ 400mg Vial	☐ Maintenance - Infuse 10mg/kg _______mg IV over 60 minutes every 4 Weeks		
	☐ 200mg/ml Autoinjector ☐ 200mg/ml PFS	☐ Inject 200mg SQ once every week		
☐ Remicade	100mg Vial	☐ Initiation - Infuse ___ mg/kg IV over 2-3 hours at week 0,2, and 6. ☐ Maintenance - Infuse ____ mg/kg IV over 2-3 hours every _____ weeks	☐ TB Skin Test ☐ Hepatitis B protocol	
☐ Inflectra	100mg Vial	☐ Initiation - Infuse _____ mg/kg IV over 2-3 hours at week 0,2, and 6 ☐ Maintenance - Infuse ______ mg/kg IV over 2-3 hours every _____ weeks	☐ TB Skin Test ☐ Hepatitis B protocol	
☐ Renflexis	100mg Vial	☐ Initiation - Infuse ____ mg/kg IV over 2-3 hours at week 0,2, and 6. ☐ Maintenance - Infuse _____ mg/kg IV over 2-3 hours every _____ weeks	☐ TB Skin Test ☐ Hepatitis B protocol	
☐ Humira	☐ 10mg/0.1ml PFS ☐ 10mg/0.2ml PFS ☐ 20mg/0.2ml PFS ☐ 20mg/0.4ml PFS ☐ 40mg/0.4ml PFS ☐ 40mg/0.4ml Pen ☐ 40mg/0.8ml PFS ☐ 40mg/0.4ml Pen	☐ Maintenance - Inject ______mg SQ every other week	☐ TB Skin Test ☐ Baseline CBC and q ______ thereafter	
☐ Cimzia	☐ 200mg/ml PFS	☐ Initiation - Inject 2ml (400mg - 2 syringes) SQ at weeks 0,2, and 4.	☐ TB Skin Test	
	☐ 200mg/ml vial	☐ Maintenance - Inject 2ml (400mg - 2 syringes) SQ every 4 weeks ☐ Maintenance - Inject 200mg SQ every other week		
☐ Stelara	☐ 45mg vial ☐ 45mg PFS	☐ Initiation - Inject ______mg SQ at weeks 0, 4, and every 12 weeks thereafter	☐ TB Skin Test	
	☐ 90mg PFS	☐ Maintenance - Inject ______mg SQ every 12 weeks		

Rheumatology Medication Enrollment Form - **Page 2 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

MEDICATION	DOSE	DIRECTIONS	LAB & ANCILLARY ORDERS	REFILLS
☐ Orencia	☐ 250mg Vial	☐ Initiation - Infuse ______mg IV over 30 minutes at week 0, 2, and 4.	☐ TB Skin Test	
	☐ 50mg/0.4ml PFS	☐ Maintenance - Infuse ______mg IV over 30 minutes every 4 weeks.	☐ CBC with Differential	
	☐ 87.5mg/0.7ml PFS	☐ Maintenance - Inject ______mg SQ every week		
	☐ 125mg/ml PFS			
	☐ 125mg/ml Clickject Autoinjector			
☐ Simponi	☐ 50mg/4ml Vial	☐ Initiation - Infuse 2mg/kg ______mg IV over 30 minutes at week 0 and 4	☐ TB Skin Test	
	☐ 50mg PFS	☐ Maintenance - Infuse 2mg/kg _____ mg IV over 30 minutes every 8 weeks	☐ CBC with Differential	
	☐ 50mg Autoinjector	☐ Maintenance - Inject 50mg SQ every month		
☐ Cosentyx	☐ 50mg Autoinjector	☐ Initiation - 150mg or 300mg SQ at 0,1,2,3, and 4 weeks		
	☐ 150mg/ml Pen	☐ Maintenance - 150mg or 300mg SQ every 4 weeks		
	☐ 150mg/ml Pen			
☐ Actemra	☐ 162mg/0.9ml PFS	☐ Initiation - Inject 162mg SQ every other week	☐ TB Skin Test	
	☐ 20mg/ml vial	☐ Initiation - Infuse _____mg IV over 60 minutes every ___ weeks	☐ CBC with Differential	
	☐ 20mg/ml vial	☐ Initiation - Infuse _____mg IV over 60 minutes every ___ weeks	☐ Liver Enzyme	
		☐ Maintenance - Infuse _____mg IV over 60 minutes every ___ weeks		
☐ Enbrel	☐ 25mg/0.5ml PFS	☐ Inject 0.8mg/kg SQ weekly (max 50mg/week)		
	☐ 25mg MDV			
	☐ 50mg/ml Mini Cartridge			
	☐ 50mg/ml PFS	☐ Inject 50mg SQ once weekly		
	☐ 50mg/ml Autoinject			
☐ Krystexxa	8mg/ml Vial	Infuse 8mg IV over 2 hours every 2 weeks		
☐ 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.	☐ CBC with Differential	
		☐ Premedicate 30 minutes prior with Methylprednisolone 100mg IV over 15 minutes.		
☐ Otezla	☐ Starter Pack	☐ Initiation - Titrate dose up to 30mg PO BID starting with 10mg qAM		
		☐ Initiation - Date starter pack provided ____________________.		
	☐ 30mg Tablets	☐ Maintenance - Take 1 (one) tablet my mouth twice daily		
☐ Xeljanz	☐ Xeljanz 5mg	☐ Take one tablet by mouth twice daily	☐ TB Skin Test	
	☐ Xeljanz XR 11mg	☐ Take one tablet by mouth daily	☐ CBC with Differential	
☐ Kineret	100mg/0.67ml PFS	☐ Inject 100mg SQ once daily		
		☐ Inject 100mg SQ every other day (patients with renal insufficiency)		
☐ Kevzara	☐ 150mg/1.14ml PFS	☐ Reduce Injection to 150mg SQ every 2 weeks to manage neutropenia, or thrombocytopenia	☐ CBC with Differential	
	☐ 150mg/1.14ml PEN			
	☐ 200mg/1.14ml PFS	☐ Inject 200mg SQ every 2 weeks		
	☐ 200mg/1.14ml PEN			

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

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.