

**Glassia Enrollment Form**

**TwelveStone Health Partners**



Date: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

**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: _____	<input type="checkbox"/> Physician's office TwelveStone Infusion Center <input type="checkbox"/> Canton <input type="checkbox"/> Chattanooga <input type="checkbox"/> Knoxville <input type="checkbox"/> Mount Juliet <input type="checkbox"/> Murfreesboro <input type="checkbox"/> Other: _____ Desired start date: _____
Next infusion date: _____	

**DIAGNOSIS**

<b>Description</b>	<b>ICD-10 Code</b>
<input type="checkbox"/> Alpha 1 Anti-Trypsin Deficiency	<input type="checkbox"/> E88.01

**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: \_\_\_\_\_

Line Access:    PIV    PICC (SL DL TL)    PORT (Huber size \_\_\_ Gauge \_\_\_ Length)    Sub-Q

MEDICATION	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw)
<input type="checkbox"/> Glassia	<input type="checkbox"/> Infuse 60 mg/kg (____mg) IV once weekly at a rate not to exceed 0.2 mL/kg/min. (TwelveStone Pharmacy to verify rate per individual patient and maintain a +/-10% margin of error on weight-based dose.)		<input type="checkbox"/> IgA Level

**LAB ORDERS - To be drawn by TwelveStone**

Order	Frequency	Frequency	Frequency
CBC w/ Differential	<input type="checkbox"/> One time prior to treatment	<input type="checkbox"/> Every treatment	<input type="checkbox"/> Q _____ weeks <input type="checkbox"/> Other: _____
CBC w/o Differential	<input type="checkbox"/> One time prior to treatment	<input type="checkbox"/> Every treatment	<input type="checkbox"/> Q _____ weeks <input type="checkbox"/> Other: _____
CMP	<input type="checkbox"/> One time prior to treatment	<input type="checkbox"/> Every treatment	<input type="checkbox"/> Q _____ weeks <input type="checkbox"/> Other: _____
BMP	<input type="checkbox"/> One time prior to treatment	<input type="checkbox"/> Every treatment	<input type="checkbox"/> Q _____ weeks <input type="checkbox"/> Other: _____
CRP	<input type="checkbox"/> One time prior to treatment	<input type="checkbox"/> Every treatment	<input type="checkbox"/> Q _____ weeks <input type="checkbox"/> Other: _____
Sed Rate	<input type="checkbox"/> One time prior to treatment	<input type="checkbox"/> Every treatment	<input type="checkbox"/> Q _____ weeks <input type="checkbox"/> Other: _____
Calcium	<input type="checkbox"/> One time prior to treatment	<input type="checkbox"/> Every treatment	<input type="checkbox"/> Q _____ weeks <input type="checkbox"/> Other: _____
Tb QuantiFERON Gold	<input type="checkbox"/> One time prior to treatment	<input type="checkbox"/> Every treatment	<input type="checkbox"/> Q _____ weeks <input type="checkbox"/> Other: _____
Hepatitis Panel	<input type="checkbox"/> One time prior to treatment	<input type="checkbox"/> Every treatment	<input type="checkbox"/> Q _____ weeks <input type="checkbox"/> Other: _____
Other:	<input type="checkbox"/> One time prior to treatment	<input type="checkbox"/> Every treatment	<input type="checkbox"/> Q _____ weeks <input type="checkbox"/> Other: _____

**Pre-medications - \*Check here for NO pre-meds \_\_\_\_\_**

Oral Acetaminophen: [ ] 325mg [ ] 500mg [ ] 650mg Cetirizine: [ ] 10mg *Diphenhydramine: [ ] 25mg [ ] 50mg Famotidine: [ ] 20mg [ ] 40mg Ibuprofen: [ ] 200mg Loratidine: [ ] 10mg Ondansetron: [ ] 4mg	IV Dexamethasone: [ ] 4mg [ ] 8mg Diphenhydramine: [ ] 25mg [ ] 50mg Famotidine: [ ] 20mg [ ] 40mg *Methylprednisolone: [ ] _____ mg IV over _____ mins Ondansetron: [ ] 4mg [ ] 8mg
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**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: \_\_\_\_\_