

Immune Globulin 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

Description	ICD-10 Code
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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)

MEDICATION	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw)
<input type="checkbox"/> Immune Globulin Brand if specified _____ (TwelveStone will assist with Payer formulary restrictions, etc.) *Excludes: Gamunex, Flebogamma, and Cuvitru	<input type="checkbox"/> Intravenous - Infuse _____ Gm(s)/day for _____ days every _____ weeks. <hr/> <input type="checkbox"/> Subcutaneous - Infuse _____ Gm(s)/day for _____ days every _____ weeks.		<input type="checkbox"/> CBC w/Differential

LAB ORDERS - To be drawn by TwelveStone

Order	Frequency	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 - *Recommended - 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: _____