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

ICD-10 Code

☐ J45.40 Moderate persistent asthma, uncomplicated ☐ J45.50 Severe persistent asthma, uncomplicated
☐ L50.1 Chronic Idiopathic Urticaria ☐ J33.______ Nasal polyps

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 any 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 ☐ Nasal Polyps - Inject _____ mg SQ every _____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/Check here for NO pre-meds ordered ______

Oral	IV
Acetaminophen: [ ] 325mg [ ]500mg [ ] 650mg Cetirizine: [ ] 10mg Diphenhydramine: [ ] 25mg [ ] 50mg Famotidine: [ ] 20mg [ ] 40mg Ibuprofen: [ ] 200mg Loratidine: [ ] 10mg Ondansetron: [ ] 4mg	Dexamethasone: [ ] 4mg [ ] 8mg Diphenhydramine: [ ] 25mg [ ] 50mg Famotidine: [ ] 20mg [ ] 40mg Methylprednisolone: [ ] ________ mg IV over ________ mins Ondansetron: [ ] 4mg [ ] 8mg **SQ/IM** *EpiPen: Use as directed ☐ x2 Pens

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: ____________

V 6.24.21

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