Immune Globulin 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 infusion date: _____ Next infusion date: _____	☐ Physician's office TwelveStone Infusion Center ☐ Canton ☐ Chattanooga ☐ Knoxville ☐ Mount Juliet ☐ Murfreesboro ☐ Other: _____ Desired start date: _____

DIAGNOSIS

Description	***ICD-10 Code***

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)
☐ Immune Globulin Brand if specified _____. (TwelveStone will assist with Payer formulary restrictions, etc.) *Excludes: Gamunex, Flebogamma, and Privigen	☐ Intravenous - Infuse ____ Gm(s)/day for ___ days every _____ weeks. ☐ Subcutaneous - Infuse ____ Gm(s)/day for___ days every _____ weeks.		☐ CBC w/Differential

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 - *Recommended - Check here for NO pre-meds _____

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

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: _____