

# Asthma/Allergy Referral 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

## DELIVERY AND ADMINISTRATION INFORMATION

Deliver to:	Place of administration:
<input type="checkbox"/> Patient's home <input type="checkbox"/> MD office <input type="checkbox"/> 1st dose to MD office, remaining refills to patient's home	<input type="checkbox"/> <b>Physician's office</b> <b>TwelveStone Infusion Center</b> <input type="checkbox"/> Canton <input type="checkbox"/> Chattanooga <input type="checkbox"/> Knoxville <input type="checkbox"/> Mount Juliet <input type="checkbox"/> Murfreesboro <input type="checkbox"/> <b>Patient's Home</b> <b>Previous treatment:</b> <input type="checkbox"/> Naïve <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy; Date of last dose: _____

## DIAGNOSIS

<input type="checkbox"/> D72.110 Idiopathic hypereosinophilic syndrome (IHES) <input type="checkbox"/> D72.111 Lymphocytic variant hypereosinophilic syndrome (LHES) <input type="checkbox"/> D72.119 Hypereosinophilic syndrome, unspecified (HES) <input type="checkbox"/> J33.0 Polyp of the nasal cavity <input type="checkbox"/> J33.1 Polypoid sinus degeneration <input type="checkbox"/> J33.8 Other polyp of sinus <input type="checkbox"/> J33.9 Nasal polyp, unspecified <input type="checkbox"/> J48.40 Moderate persistent asthma, uncomplicated	<input type="checkbox"/> J45.50 Severe persistent asthma, uncomplicated <input type="checkbox"/> J45.51 Severe persistent asthma with (acute) exacerbation <input type="checkbox"/> J82.83 Eosinophilic asthma <input type="checkbox"/> L20._____ Moderate to severe atopic dermatitis <input type="checkbox"/> L50.1 Idiopathic urticaria <input type="checkbox"/> M30.1 EGPA/Polyarteritis with lung involvement Other: _____
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## OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

Medical Card (Front and Back)  
  Prescription Card (Front and Back)  
  Patient Demographics  
 Clinic notes and labs  
  Allergies and current medication list  
  Last 4 digits of social \_\_\_\_\_  
 Patient weight \_\_\_\_\_ kg  
  Patient height \_\_\_\_\_ inches

Medication	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Dupixent	<input type="checkbox"/> 200mg PFS <input type="checkbox"/> 300mg PFS <input type="checkbox"/> 200mg pre-filled pen <input type="checkbox"/> 300mg pre-filled pen	<input type="checkbox"/> Inject 400mg (two 200mg injections in different sites) SQ on Day 1, followed by 200mg on Day 15 <input type="checkbox"/> Inject 200mg SQ every other week <input type="checkbox"/> Inject 600mg (two 300mg injections in different sites) SQ on Day 1, followed by 300mg on Day 15 <input type="checkbox"/> Inject 300mg SQ every other week	<input type="checkbox"/> 28 day supply <input type="checkbox"/> 84 day supply	
<input type="checkbox"/> Fasenra	<input type="checkbox"/> 30mg PFS, Provider-administered <input type="checkbox"/> 30mg autoinjector, Self-administered	<input type="checkbox"/> Inject 30mg SQ once every 4 weeks for 3 doses <input type="checkbox"/> Inject 30mg SQ once every 8 weeks	<input type="checkbox"/> 28 day supply <input type="checkbox"/> 84 day supply	
<input type="checkbox"/> Nucala	<input type="checkbox"/> 100mg vial, Provider-administered <input type="checkbox"/> 100mg PFS, Self-administered <input type="checkbox"/> 100mg autoinjector, Self-administered	<input type="checkbox"/> Inject 100mg SQ once every 4 weeks <input type="checkbox"/> Inject 300mg (three 100mg injections in different sites) once every 4 weeks	<input type="checkbox"/> 28 day supply <input type="checkbox"/> 84 day supply	
<input type="checkbox"/> Xolair	<input type="checkbox"/> 75mg PFS <input type="checkbox"/> 150mg PFS <input type="checkbox"/> 150mg vial	<input type="checkbox"/> Inject _____mg SQ once every 2 weeks <input type="checkbox"/> Inject _____mg SQ once every 4 weeks	<input type="checkbox"/> 28 day supply <input type="checkbox"/> 84 day supply	
<input type="checkbox"/> EpiPen	<input type="checkbox"/> 0.3mg	Use as directed	<input type="checkbox"/> 1 pen	
<input type="checkbox"/> EpiPen Jr.	<input type="checkbox"/> 0.15mg	Use as directed	<input type="checkbox"/> 2-Pak	

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

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