

TwelveStone Health Partners

Fax Referral To:

(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012



XOLAIR ORDER FORM

| | |
|--|--|
| Date: _____ | ICD-10 Code: _____ |
| Patient Name: _____ | Allergies: _____ |
| Date of Birth: _____ | Weight: _____ lbs OR _____ kg |
| Therapy Status | Provider Information |
| <input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____ | Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____ |

MEDICATION ORDER

| | | | |
|---------------------------------|---|---|---|
| <input type="checkbox"/> Xolair | Administer _____mg of Xolair subcutaneously every _____ weeks. A two-hour observation period is encouraged following the first three injections. A 30 minute observation period will be encouraged for subsequent doses as per policy. <input type="checkbox"/> By checking this box, you indicate that your patient is not subject to an observation period and may exit the facility immediately following injection. | Refills x one year from date of signature unless indicated below <input type="checkbox"/> _____ Refills | <input type="checkbox"/> Patient is required to have EpiPen with each treatment <input type="checkbox"/> EpiPen 0.3mg autoinjector to be administered SQ or IM to outer thigh as directed in the event of a life-threatening allergic reaction. Dispense: 2 pens Refills: 2 refills <input type="checkbox"/> Patient is NOT required to have EpiPen |
|---------------------------------|---|---|---|

PRE-MEDICATIONS

| | |
|---|---|
| <input type="checkbox"/> Acetaminophen: _____ ^{Oral} 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10 mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other _____ | <input type="checkbox"/> Dexamethasone: _____ ^{IV} 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone 125mg <input type="checkbox"/> Hydrocortisone 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other _____ |
|---|---|

LAB ORDERS (Please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

| | |
|---|---|
| **Surveillance lab ordering, and monitoring is the responsibility of the prescriber** | (Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"> History & Physical, Last Office Visit Note Patient Demographics and Insurance Information Medication List Recent Lab Work |
|---|---|

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

| | |
|--|---|
| Dispense as Written: _____ Prescriber Name | Substitution Allowed: _____ Prescriber Name |
| _____ Date | _____ Date |