Rheumatology Medication 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 Suite ☐ TwelveStone Home Infusion ☐ Other: ______________________ Desired Start Date: ______________________

DIAGNOSIS

Description	*ICD-10 Code*
☐ Rheumatoid Arthritis ☐ Lupus Erythematosus ☐ Ankylosing Spondylitis ☐ Gout ☐ Arthritic Psoriasis	☐ M06.9 ☐ M32.9 ☐ M45 ☐ M10 ☐ L40.5

OTHER REQUIRED DOCUMENTATION *(Please attach documents as needed)*

☐ This signed order form ☐ History and Physical ☐ TB and Hep B Documentation

☐ 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/Lbs Height:__________Inches/CM Allergies: ______________________

Line Access: ☐ PIV ☐ PICC (SL DL TL) ☐ PORT (Huber size_____Gauge_____Length) ☐ Sub-Q

Location: ☐ Hands ☐ Feet ☐ Knees ☐ Spine ☐ Other ______________________

Currently Received and/or Prior Failed Therapies:	☐ Biologics: ______________________ ☐ Corticosteroids ☐ Methotrexate ☐ NSAIDS ☐ Other: ______________ Length of Treatment: ______________________ Reason for Discontinuing or Adding Supplmental Tx:______________	Contraindicated Medication: ____________ Reason: ____________

MEDICATION	DOSE	DIRECTIONS	LAB & ANCILLARY ORDERS	REFILLS
☐ Benlysta	☐ 120mg Vial	☐ Initiation - Infuse 10mg/kg _______ mg IV over 60 minutes at week 0,2, and 4.	☐ Baseline Liver Enzymes ☐ TB Skin Test	
	☐ 400mg Vial	☐ Maintenance - Infuse 10mg/kg _______mg IV over 60 minutes every 4 Weeks		
	☐ 200mg/ml Autoinjector ☐ 200mg/ml PFS	☐ Inject 200mg SQ once every week		
☐ Remicade	100mg Vial	☐ Initiation - Infuse ___ mg/kg IV over 2-3 hours at week 0,2, and 6. ☐ Maintenance - Infuse ____ mg/kg IV over 2-3 hours every _____ weeks	☐ TB Skin Test ☐ Hepatitis B protocol	
☐ Inflectra	100mg Vial	☐ Initiation - Infuse _____ mg/kg IV over 2-3 hours at week 0,2, and 6 ☐ Maintenance - Infuse ______ mg/kg IV over 2-3 hours every _____ weeks	☐ TB Skin Test ☐ Hepatitis B protocol	
☐ Renflexis	100mg Vial	☐ Initiation - Infuse ____ mg/kg IV over 2-3 hours at week 0,2, and 6. ☐ Maintenance - Infuse _____ mg/kg IV over 2-3 hours every _____ weeks	☐ TB Skin Test ☐ Hepatitis B protocol	
☐ Humira	☐ 10mg/0.1ml PFS ☐ 10mg/0.2ml PFS ☐ 20mg/0.2ml PFS ☐ 20mg/0.4ml PFS ☐ 40mg/0.4ml PFS ☐ 40mg/0.4ml Pen ☐ 40mg/0.8ml PFS ☐ 40mg/0.4ml Pen	☐ Maintenance - Inject ______mg SQ every other week	☐ TB Skin Test ☐ Baseline CBC and q ______ thereafter	
☐ Cimzia	☐ 200mg/ml PFS	☐ Initiation - Inject 2ml (400mg - 2 syringes) SQ at weeks 0,2, and 4.	☐ TB Skin Test	
	☐ 200mg/ml vial	☐ Maintenance - Inject 2ml (400mg - 2 syringes) SQ every 4 weeks ☐ Maintenance - Inject 200mg SQ every other week		
☐ Stelara	☐ 45mg vial ☐ 45mg PFS	☐ Initiation - Inject ______mg SQ at weeks 0, 4, and every 12 weeks thereafter	☐ TB Skin Test	
	☐ 90mg PFS	☐ Maintenance - Inject ______mg SQ every 12 weeks		

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MEDICATION	DOSE	DIRECTIONS	LAB & ANCILLARY ORDERS	REFILLS
☐ Orencia	☐ 250mg Vial	☐ Initiation - Infuse ______mg IV over 30 minutes at week 0, 2, and 4.	☐ TB Skin Test ☐ CBC with Differential	
	☐ 50mg/0.4ml PFS	☐ Maintenance - Infuse ______mg IV over 30 minutes every 4 weeks.		
	☐ 87.5mg/0.7ml PFS ☐ 125mg/ml PFS ☐ 125mg/ml Clickject Autoinjector	☐ Maintenance - Inject ______mg SQ every week		
☐ Simponi	☐ 50mg/4ml Vial	☐ Initiation - Infuse 2mg/kg ______mg IV over 30 minutes at week 0 and 4	☐ TB Skin Test ☐ CBC with Differential	
	☐ 50mg PFS	☐ Maintenance - Infuse 2mg/kg _____ mg IV over 30 minutes every 8 weeks		
	☐ 50mg Autoinjector	☐ Maintenance - Inject 50mg SQ every month		
☐ Cosentyx	☐ 50mg Autoinjector	☐ Initiation - 150mg or 300mg SQ at 0,1,2,3, and 4 weeks		
	☐ 150mg/ml Pen ☐ 150mg/ml Pen	☐ Maintenance - 150mg or 300mg SQ every 4 weeks		
☐ Actemra	☐ 162mg/0.9ml PFS	☐ Initiation - Inject 162mg SQ every other week	☐ TB Skin Test ☐ CBC with Differential ☐ Liver Enzyme	
	☐ 20mg/ml vial	☐ Initiation - Infuse _____mg IV over 60 minutes every ___ weeks		
	☐ 20mg/ml vial	☐ Initiation - Infuse _____mg IV over 60 minutes every ___ weeks ☐ Maintenance - Infuse _____mg IV over 60 minutes every ___ weeks		
☐ Enbrel	☐ 25mg/0.5ml PFS ☐ 25mg MDV ☐ 50mg/ml Mini Cartridge	☐ Inject 0.8mg/kg SQ weekly (max 50mg/week)		
	☐ 50mg/ml PFS ☐ 50mg/ml Autoinject	☐ Inject 50mg SQ once weekly		
☐ Krystexxa	8mg/ml Vial	Infuse 8mg IV over 2 hours every 2 weeks		
☐ Rituxan	10mg/ml (100ml, 500ml)	☐ Infuse 1000mg IV at increments of 50mg/hr every 30 minutes to a max rate of 400mg/hr x 2 doses separated by 2 weeks. ☐ Premedicate 30 minutes prior with Methylprednisolone 100mg IV over 15 minutes.	☐ CBC with Differential	
☐ Otezla	☐ Starter Pack	☐ Initiation - Titrate dose up to 30mg PO BID starting with 10mg qAM ☐ Initiation - Date starter pack provided ____________________.		
	☐ 30mg Tablets	☐ Maintenance - Take 1 (one) tablet my mouth twice daily		
☐ Xeljanz	☐ Xeljanz 5mg	☐ Take one tablet by mouth twice daily	☐ TB Skin Test ☐ CBC with Differential	
	☐ Xeljanz XR 11mg	☐ Take one tablet by mouth daily		
☐ Kineret	100mg/0.67ml PFS	☐ Inject 100mg SQ once daily ☐ Inject 100mg SQ every other day (patients with renal insufficiency)		
☐ Kevzara	☐ 150mg/1.14ml PFS ☐ 150mg/1.14ml PEN	☐ Reduce Injection to 150mg SQ every 2 weeks to manage neutropenia, or thrombocytopenia	☐ CBC with Differential	
	☐ 200mg/1.14ml PFS ☐ 200mg/1.14ml PEN	☐ Inject 200mg SQ every 2 weeks		

Premedication(s):

- ☐ Diphenhydramine 25-50 mg po – 25mg #2 per dose
- ☐ Acetaminophen 325-650 mg po – 325mg #2 per dose
- ☐ Methylprednisolone______mg IV over_______mins
- ☐ Other: ____

Ancillary Orders:

- ☐ NaCl 0.9% 5-10ml IV before and after infusion
- ☐ Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN
- ☐ Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN
- ☐ All infusion supplies necessary to administer the medication
- ☐ Anaphylaxis Kit

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

By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers.

Physician's Phone #	Physician's NPI #	Physician's Fax #	Physician's Address
Dispense as Written	Date	Substitution Allowed	Date

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