Asthma/Allergy Referral 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

DELIVERY AND ADMINISTRATION INFORMATION

Deliver to:	Place of administration:
☐ Patient's home ☐ MD office ☐ 1st dose to MD office, remaining refills to patient's home	☐ **Physician's office** **TwelveStone Infusion Center** ☐ Canton ☐ Chattanooga ☐ Knoxville ☐ Mount Juliet ☐ Murfreesboro ☐ **Patient's Home** **Previous treatment:** ☐ Naïve ☐ Restart ☐ Continued therapy; Date of last dose:______________________

DIAGNOSIS

☐ D72.110 Idiopathic hypereosinophilic syndrome (IHES)	☐ J45.50 Severe persistent asthma, uncomplicated
☐ D72.111 Lymphocytic variant hypereosinophilic syndrome (LHES)	☐ J45.51 Severe persistent asthma with (acute) exacerbation
☐ D72.119 Hypereosinophilic syndrome, unspecified (HES)	☐ J82.83 Eosinophilic asthma
☐ J33.0 Polyp of the nasal cavity	☐ L20.______ Moderate to severe atopic dermatitis
☐ J33.1 Polypoid sinus degeneration	☐ L50.1 Idiopathic urticaria
☐ J33.8 Other polyp of sinus	☐ M30.1 EGPA/Polyarteritis with lung involvement
☐ J33.9 Nasal polyp, unspecified	
☐ J48.40 Moderate persistent asthma, uncomplicated	Other:______________________

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
☐ Dupixent	☐ 200mg PFS ☐ 300mg PFS ☐ 200mg pre-filled pen ☐ 300mg pre-filled pen	☐ Inject 400mg (two 200mg injections in different sites) SQ on Day 1, followed by 200mg on Day 15 ☐ Inject 200mg SQ every other week ☐ Inject 600mg (two 300mg injections in different sites) SQ on Day 1, followed by 300mg on Day 15 ☐ Inject 300mg SQ every other week	☐ 28 day supply ☐ 84 day supply	
☐ Fasenra	☐ 30mg PFS, Provider-administered ☐ 30mg autoinjector, Self-administered	☐ Inject 30mg SQ once every 4 weeks for 3 doses ☐ Inject 30mg SQ once every 8 weeks	☐ 28 day supply ☐ 84 day supply	
☐ Nucala	☐ 100mg vial, Provider-administered ☐ 100mg PFS, Self-administered ☐ 100mg autoinjector, Self-administered	☐ Inject 100mg SQ once every 4 weeks ☐ Inject 300mg (three 100mg injections in different sites) once every 4 weeks	☐ 28 day supply ☐ 84 day supply	
☐ Xolair	☐ 75mg PFS ☐ 150mg PFS ☐ 150mg vial	☐ Inject ________mg SQ once every 2 weeks ☐ Inject ________mg SQ once every 4 weeks	☐ 28 day supply ☐ 84 day supply	
☐ EpiPen	☐ 0.3mg	Use as directed	☐ 1 pen	
☐ EpiPen Jr.	☐ 0.15mg	Use as directed	☐ 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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