TwelveStone Health Partners

Fax Referral To:
(800) 223-4063

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

CINQAIR ORDER FORM

Date:	ICD-10 Code: ____________________________
Patient Name:	Allergies: _______________________________
Date of Birth:	Weight: _________lbs OR _____________kg

Therapy Status	Provider Information
☐ New Start ☐ Continuing Therapy: Last Dose: ____________________	Ordering Provider: _________________________ Provider NPI: ____________________________ Provider Phone: ___________________________ Provider Fax: ____________________________ Provider Address: _________________________

MEDICATION ORDER

☐ Cinqair	☐ Cinqair 3mg/kg IV every four weeks per protocol ☐ Cinqair ______mg/kg IV every ________ weeks per protocol	***Refills x one year from date of signature unless indicated below.*** ☐ ______ Refills

PRE-MEDICATIONS

Oral	IV
☐ Acetaminophen: ___325mg ___500mg ___♦650mg	☐ Dexamethasone: ___4mg ___8mg
☐ Loratadine: 10 mg	☐ Diphenhydramine: ___25mg __50mg
☐ Cetirizine: 10mg	☐ Famotidine: ___20mg ___40mg
☐ Diphenhydramine: ___25mg ___50mg	☐ Methylprednisolone 125mg
☐ Famotidine: ___20mg ___40mg	☐ Hydrocortisone 100mg
☐ Ibuprofen: ___200mg ___400mg ___600mg	☐ Ondansetron: ___4mg ___8mg
☐ Ondansetron: ___4mg ___8mg	☐ Other________________________
☐ 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) • 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:	Substitution Allowed:
________________________ ________ Prescriber Name Date	________________________ ________ Prescriber Name Date