Immune Globulin 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:

Last infusion date: ____________________

Next infusion date: ____________________

If NO, please indicate desired location for first dose:

☐ Physician's office
TwelveStone Infusion Center
☐ Canton ☐ Chattanooga ☐ Knoxville ☐ Mount Juliet ☐ Murfreesboro
☐ Other: ____________________
Desired start date: ____________________

DIAGNOSIS

Description	***ICD-10 Code***

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

☐ This signed order form ☐ History and Physical

☐ 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 Height: __________ Inches/CM BSA: __________ Allergies: ____________________

Line Access: ☐ PIV ☐ PICC (SL DL TL) ☐ PORT (Huber size____Gauge____Length)

MEDICATION	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw)
☐ Immune Globulin Brand if specified ____________________. (TwelveStone will assist with Payer formulary restrictions, etc.) *Excludes: Gamunex, Flebogamma, and Privigen	☐ Intravenous - Infuse ____ Gm(s)/day for ___ days every _____ weeks. ------------------------------ ☐ Subcutaneous - Infuse ____ Gm(s)/ day for___ days every _____ weeks.		☐ CBC w/Differential

LAB ORDERS - To be drawn by TwelveStone

Order	Frequency			
CBC w/ Differential	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: ____________
CBC w/o Differential	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: ____________
CMP	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: ____________
BMP	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: ____________
CRP	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: ____________
Sed Rate	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: ____________
Calcium	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: ____________
Tb QuantiFERON Gold	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: ____________
Hepatitis Panel	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: ____________
Other:	☐ One time prior to treatment	☐ Every treatment	☐ Q _____ weeks	☐ Other: ____________

Pre-medications - *Recommended - Check here for NO pre-meds ______

Oral

*Acetaminophen: [ ] 325mg [ ]500mg [ ] 650mg
Cetirizine: [ ] 10mg
*Diphenhydramine: [ ] 25mg [ ] 50mg
*Famotidine: [ ] 20mg [ ] 40mg
*Ibuprofen: [ ] 200mg
*Loratidine: [ ] 10mg
Ondansetron: [ ] 4mg

IV

Dexamethasone: [ ] 4mg [ ] 8mg
Diphenhydramine: [ ] 25mg [ ] 50mg
Famotidine: [ ] 20mg [ ] 40mg
*Methylprednisolone: [ ] ________ mg IV over ________ mins
Ondansetron: [ ] 4mg [ ] 8mg

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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