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
☐ New Start ☐ Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

MEDICATION ORDER

☐ 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. ☐ 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 ☐ _____ Refills	☐ Patient is required to have EpiPen with each treatment ☐ 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 ☐ Patient is NOT required to have EpiPen

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