

# TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012



## NUCALA ORDER FORM

Date: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Allergies: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs OR \_\_\_\_\_ kg

**Therapy Status**  
 New Start  
 Continuing Therapy:  
Last Dose: \_\_\_\_\_

## PROVIDER INFORMATION

Ordering Provider: \_\_\_\_\_ Provider Fax: \_\_\_\_\_  
Provider NPI: \_\_\_\_\_ Provider Address: \_\_\_\_\_  
Provider Phone: \_\_\_\_\_

## ADMINISTRATION

- Vial (Provider- Administered)
- PFS (Self- Administered)
- Autoinjector (Self- Administered)

### Place of Administration:

- TwelveStone Infusion Center
- Patient's Home
- MD Office
- Other \_\_\_\_\_

## MEDICATION ORDER

Nucala

- Nucala 100mg SQ every four weeks per protocol.
- Nucala \_\_\_\_\_mg SQ every \_\_\_\_\_ weeks per protocol.

Refills x one year from date of signature unless indicated below.

\_\_\_\_\_ Refills

## PRE-MEDICATIONS

### Oral

- Acetaminophen: \_\_\_\_\_ 325mg \_\_\_\_\_ 500mg \_\_\_\_\_ 650mg
- Loratadine: 10mg
- Cetirizine: 10mg
- Diphenhydramine: \_\_\_\_\_ 25mg \_\_\_\_\_ 50mg
- Famotidine: \_\_\_\_\_ 20mg \_\_\_\_\_ 40mg
- Ibuprofen: \_\_\_\_\_ 200mg \_\_\_\_\_ 400mg \_\_\_\_\_ 600mg
- Ondansetron: \_\_\_\_\_ 4mg \_\_\_\_\_ 8mg
- Other: \_\_\_\_\_

### IV

- Dexamethasone: \_\_\_\_\_ 4mg \_\_\_\_\_ 8mg
- Diphenhydramine: \_\_\_\_\_ 25mg \_\_\_\_\_ 50mg
- Famotidine: \_\_\_\_\_ 20mg \_\_\_\_\_ 40mg
- Methylprednisolone: 125mg
- Hydrocortisone: 100mg
- Ondansetron: \_\_\_\_\_ 4mg \_\_\_\_\_ 8mg
- Other: \_\_\_\_\_

## LAB ORDERS (please indicate any labs to be drawn and frequency)

(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

\*\*Surveillance lab ordering and monitoring is the responsibility of the prescriber\*\*

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

Dispense as Written:

Substitution Allowed: