Asthma/Allergy 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

DELIVERY AND ADMINISTRATION INFORMATION

Deliver To:

- ☐ Patient's Home
- ☐ MD Office
- ☐ 1st dose to MD office, remaining refills to patient's home

Place of Administration:

- ☐ Physician's Office
- ☐ TwelveStone Infusion Center: _____
- ☐ Patient's Home

Previous Treatment: ☐ Naïve ☐ Restart ☐ Continued Therapy:

☐ Date of Last Dose: _____

DIAGNOSIS

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

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

- ☐ Medical Card (Front & Back)
- ☐ Prescription Card (Front & Back)
- ☐ Patient Demographics
- ☐ Clinic Notes & Labs (CBC w/ diff, IgE, etc.)
- ☐ Pulmonary Function Tests
- ☐ Allergies & 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-Administerd	☐ 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-Administerd ☐ 100mg AutoInjector, Self-Administerd	☐ 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	
☐ TEZSPIRE	☐ 210mg PFS, Provider Administered	☐ Inject 210mg SQ 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: _____

V 11.10.23