TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

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

☐ New Start

☐ Continuing Therapy:
Last Dose: ____________________

PROVIDER INFORMATION

Ordering Provider: ____________________ Provider Fax: ____________________

Provider NPI: ____________________ Provider Address: ____________________

Provider Phone: ____________________

ADMINISTRATION

Place of Administration: ☐ TwelveStone Infusion Center ☐ MD Office ☐ Other ____________________

MEDICATION ORDER

Xolair			
Xolair	✓ Administer ________ mg of Xolair subcutaneously every ________ weeks. ✓ *TwelveStone staff will encourage patients to remain on-site for a two hour observation following their first three injections of Xolair, followed by a 30 minute observation period for each subsequent injection 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	***Per TwelveStone policy, patient must have an Epipen on hand at each appointment. If patient does not have an Epipen, the following will be ordered unless otherwise indicated:*** ✓ **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** ☐ *Urticaria Diagnosis Only:* *By checking this box, you indicate that your patient does not require an Epipen prescription and does not need an Epipen on hand at each appointment.*

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)

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 the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:		Substitution Allowed:	
Prescriber Name ____________________	Date ________	Prescriber Name ____________________	Date ________

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