

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com



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)

OTHER REQUIRED DOCUMENTATION

(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:

Prescriber Name _____

Date _____

Prescriber Name _____

Date _____