TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: intake@12stonehealth.com

TYENNE 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: ______________________

MEDICATION ORDER

Tyenne

Therapeutic interchange to insurance preferred biosimilar (Actemra) authorized unless otherwise specified below:

☐ Do not use biosimilar

☐ Tyenne ________ mg/kg IV every ________ weeks to be given over one hour.

☐ (<100kg) Tyenne 162mg SQ to be given every other week.

☐ (≥100kg) Tyenne 162mg SQ to be given weekly.

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

________ Refills

Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:

✓ TB Quant Gold within the past 12 months
✓ Hepatitis B Surface Antigen
✓ Absolute Neutrophil Count, Platelet Count, and ALT/AST within the past 60days

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

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

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

Dispense as Written:

______________________ ______________
Prescriber Name Date

Substitution Allowed:

______________________ ______________
Prescriber Name Date

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