

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com



UPLIZNA ORDER FORM

Date: _____	ICD-10 Code: _____	Therapy Status
Patient Name: _____	Allergies: _____	<input type="checkbox"/> New Start
Date of Birth: _____	Weight: _____ lbs OR _____ kg	<input type="checkbox"/> Continuing Therapy: Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

MEDICATION ORDER

Uplizna	<input type="checkbox"/> Initiation: Infuse Uplizna 300mg IV on Day 1 and Day 15. <input type="checkbox"/> Maintenance: Infuse 300mg IV every six months. If first maintenance dose, schedule six months from Day 1 of initiation phase. <input checked="" type="checkbox"/> Pre-medications will be given as indicated below unless designated otherwise. Antihistamine dosage and route to be determined by on site provider if not specified.	Refills for one year from date of signature unless indicated below. _____ Refills	<p>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</p> <input checked="" type="checkbox"/> Hepatitis B Surface Antigen. <input checked="" type="checkbox"/> Hepatitis B Core Antibody Total (Not Core IgM) <input checked="" type="checkbox"/> Negative TB Quantiferon Gold, or TB Skin Test within the last 12 months. <input checked="" type="checkbox"/> Quantitative Serum Immunoglobulin Screening (Prior to initiation phase of treatment)
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PRE-MEDICATIONS

<p>Oral</p> <input checked="" type="checkbox"/> Acetaminophen: _____ 325mg _____ 500mg <input checked="" type="checkbox"/> 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input checked="" type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____	<p>IV</p> <input type="checkbox"/> Dexamethasone: _____ 4mg _____ 8mg <input checked="" type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input checked="" type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other: _____
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LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

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) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
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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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