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

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	✓ 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 for 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

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