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

# FASENRA 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:**

| 1st | 2nd | | | | |
|---|---|---|---|---|---|
| ☐ | ☐ | PFS (Provider- Administered) | ☐ TwelveStone Infusion Center | ☐ MD Office | |
| ☐ | ☐ | Autoinjector (Self- Administered) | ☐ MD Office | ☐ Patient's Home | ☐ Other _____ |

## MEDICATION ORDER

| | | |
|---|---|---|
| **Fasenra** | ☐ Loading Dose: Inject 30mg SQ once every 4 weeks for 3 doses<br>☐ Maintenance Dose: Inject 30mg SQ once every 8 weeks | Refills for one year from date of signature unless indicated below.<br>_____ 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)

**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)*

*By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.*

Dispense as Written:

_____ _____
Prescriber Signature Date

Substitution Allowed:

_____ _____
Prescriber Signature Date