

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com



TEZSPIRE ORDER FORM

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

PROVIDER INFORMATION

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

MEDICATION ORDER

Tezspire	<input type="checkbox"/> Tezspire 210mg PFS to be administered subcutaneously every four weeks per protocol.	Refills for one year from date of signature unless indicated below. _____ Refills
	<input type="checkbox"/> Tezspire _____mg PFS to be administered every _____ weeks per protocol. Please fax order for Pre-Filled Pen to Tezspire Together 1-888-388-6016. **Twelvestone does not have access to Pens**	

PRE-MEDICATIONS

Oral <input type="checkbox"/> Acetaminophen: _____325mg _____500mg _____650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input 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: _____	IV <input type="checkbox"/> Dexamethasone: _____4mg _____8mg <input type="checkbox"/> Diphenhydramine: _____25mg _____50mg <input type="checkbox"/> Famotidine: _____20mg _____40mg <input 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)

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.

_____ Prescriber Signature	_____ Date
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