

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com



TYENNE ORDER FORM

Patient Name: _____ ICD-10 Code: _____
Date of Birth: _____ Allergies: _____
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:

- Negative TB result and date: _____, Hepatitis B Surface Antigen

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)

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.

Prescriber Signature

Date