

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com



UPLIZNA 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

- Uplizna**
- Initiation: Infuse Uplizna 300mg IV on Day 1 and Day 15.
 - Maintenance: Infuse 300mg IV every six months. If first maintenance dose, schedule six months from Day 1 of initiation phase.
 - 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

Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:

- Hepatitis B Surface Antigen.
- Hepatitis B Core Antibody Total (Not Core IgM)
- Negative TB result and date: _____
- Quantitative Serum Immunoglobulin Screening (Prior to initiation phase of treatment)

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

Surveillance lab ordering and monitoring is the responsibility of the prescriber

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