

# TwelveStone Health Partners

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## KIMYRSA 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

**Kimyrsa**

- ✓ Kimyrsa 1,200mg IV x one dose over one hour per protocol.
- ✓ The use of unfractionated heparin sodium is contraindicated for 120 hours (5 days) after Kimyrsa administration

## 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

\*\*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)

- 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