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

RYSTIGGO 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

Rystiggo

☐ Weight less than 50kg: Infuse 420mg subcutaneously weekly for 6 weeks.

☐ Weight 50kg to less than 100kg: Infuse 560mg subcutaneously weekly for 6 weeks.

☐ Weight 100kg and above: Infuse 840mg subcutaneously weekly for 6 weeks.

I authorize _____ additional cycles of treatment. Each subsequent cycle will be scheduled 63 days from the start of the previous treatment cycle, unless otherwise specified. The ordering of subsequent cycles of treatment should be based on clinical evaluation.

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 615-278-3355)

- 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

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