

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: referral@12stonehealth.com

**UNLOXCYT DEFICIENCY ORDER FORM**

Patient Name: _____	ICD-10 Code: _____	Therapy Status ☐ New Start ☐ 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

UNLOXCYT (Monotherapy)	☐ Infuse 1200mg IV every 3 weeks	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: ✓ LFTs, TSH, T3, T4, and Creatinine To be drawn at: ☐ Infusion Center to draw ☐ Independent lab to draw ☐ MD office to draw
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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: _____
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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 615-278-3382) • 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 _____