

**Human Growth Hormone  
Therapy Enrollment Form**

**TwelveStone Health Partners**

**Fax Referral To:  
(800) 223-4063**



Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Direct Phone: (615) 278-3350  
Toll Free: (844) 893-0012

**PREVIOUS ADMINISTRATION**

<b>If YES, please provide the following information:</b>	<b>If NO, please indicate desired location for first dose:</b>
Last Injection Date: _____ Next Injection Date: _____	<input type="checkbox"/> Physician's Office <input type="checkbox"/> TwelveStone Infusion Center <input type="checkbox"/> Home Administration <input type="checkbox"/> Pharmacy to Schedule Injection <input type="checkbox"/> Other: _____ Desired Start Date: _____

**DIAGNOSIS**

<b>Description:</b>	<b>ICD-10 Code:</b>
<b>Secondary Endocrine Diagnosis Description:</b>	<b>Secondary Endocrine Diagnosis ICD-10 Code:</b>

**OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)**

<input type="checkbox"/> This signed order form	<input type="checkbox"/> History and Physical
<input type="checkbox"/> Patient Demographics and Insurance Information	<input type="checkbox"/> Clinical progress notes, lab work (including any necessary supportive Documentation for HGH therapy)

**CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)**

Patient Weight: \_\_\_\_\_ Kg/Lbs    Height: \_\_\_\_\_ Inches/CM    Allergies: \_\_\_\_\_

Patient has received injection training     Physician's office to provide injection training     TwelveStone Health Partners to arrange injection

MEDICATION	DOSAGE FORM	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Humatrope	Pen: <input type="checkbox"/> 6mg <input type="checkbox"/> 12mg <input type="checkbox"/> 24mg	Inject _____mg Subcutaneously _____ days/week		
	PFS: <input type="checkbox"/> 6mg <input type="checkbox"/> 12mg <input type="checkbox"/> 24mg			
	Vial: <input type="checkbox"/> 5mg			
<input type="checkbox"/> Norditropin	Flexpro: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 15mg	Inject _____mg Subcutaneously _____ days/week		
	PF Pen: <input type="checkbox"/> 30mg/3ml			
<input type="checkbox"/> Saizen	Click Easy Device: <input type="checkbox"/> 8.8mg	Inject _____mg Subcutaneously _____ days/week		
	Vial: <input type="checkbox"/> 5mg <input type="checkbox"/> 8.8mg			
<input type="checkbox"/> Genotropin	Pen: <input type="checkbox"/> 5mg <input type="checkbox"/> 12mg	Inject _____mg Subcutaneously _____ days/week		
	Mini Quick: <input type="checkbox"/> 0.2mg <input type="checkbox"/> 0.4mg <input type="checkbox"/> 0.6mg <input type="checkbox"/> 0.8mg <input type="checkbox"/> 1.0mg <input type="checkbox"/> 1.2mg <input type="checkbox"/> 1.4mg <input type="checkbox"/> 1.6mg <input type="checkbox"/> 1.8mg <input type="checkbox"/> 2.0mg			
<input type="checkbox"/> Serostim	Cartridges: 6mg	Inject _____mg Subcutaneously _____ days/week		
<input type="checkbox"/> Omnitrope	Pen: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg	Inject _____mg Subcutaneously _____ days/week		
	Vial: <input type="checkbox"/> 5.8ml			
<input type="checkbox"/> Zorbtive	Vial: 8.8mg	Inject _____mg Subcutaneously _____ days/week		
<input type="checkbox"/> Nutropin AQ	Nuspin: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 20mg	Inject _____mg Subcutaneously _____ days/week		
	Vial: <input type="checkbox"/> 10mg			
<input type="checkbox"/> Lupron Depot PED	PFS: <input type="checkbox"/> 7.5mg <input type="checkbox"/> 11.25mg <input type="checkbox"/> 15mg	Inject Intramuscularly once a month		

**By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**  
By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers.

Dispense as Written      Printed Name      Substitution Allowed      Date

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