

**Women's Health 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

If YES, please provide the following information:

Last Infusion Date: _____

Next Infusion Date: _____

If NO, please indicate desired location for first dose:

Physician's Office

TwelveStone Infusion Center

TwelveStone Home Infusion

Other: _____

Desired Start Date: _____

DIAGNOSIS

Description

ICD-10 Code

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

This signed order form

History and Physical

Patient Demographics and Insurance Information

Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

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

Patient Weight: _____ Kg/Lbs Height: _____ Inches/CM Allergies: _____

Line Access: PIV PICC (SL DL TL) PORT (Huber size _____ Gauge _____ Length) Sub-Q

MEDICATION & DOSE

LAB ORDERS

Hyperemesis:

- Ondansetron Continuous Sub-Q Infusion 1 mg/hr
- Ondansetron Intermittent IV Injection _____ mg every 8 hours
- Metoclopramide Continuous IV Infusion _____ mg/hr
- Metoclopramide Intermittent IV Injection _____ mg every _____ hours

TPN/Hydration:

- Hydration –
- D5 1/2NS IV _____ Liters x _____ days NS IV _____ Liters x _____ days
- Ringers Lactate IV _____ Liters x _____ days D5/Ringers Lactate IV _____ Liters x _____ days
- Total Parenteral Nutrition (Pharmacy to provide custom formula; Central Line Required)

Iron Deficiency Anemia:

- Venofer IV infusion _____ mg weekly over _____ minutes
- Injectafer (Pt < 50kg) 15mg/kg – 2 doses given at least 7 days apart
- Injectafer (Pt > 50kg) 750mg – 2 doses given at least 7 days apart
- Infed _____ mg IV daily at a rate not to exceed 50mg/min
- Infed _____ mg IM daily using Z-track technique

HGB, HCT, TIBC, Ferritin

Endometriosis/Uterine Fibroid:

- Lupron 3.75mg IM every month x _____ doses
- Lupron 11.25mg IM every 3 months x _____ doses
- Lupron _____ mg IM every _____ month(s) x _____ doses

Pyelonephritis/Complicated UTI:

- Ceftriaxone 1gm IV daily x 7 days
- Ceftriaxone 2gm IV daily x 7 days
- Invanz 1gm IV daily x 7 days

CBC, BMP

Osteoporosis:

- Forteo Pen 20mcg SQ daily
- Tymlos Pen 80mcg SQ daily
- Ibandronate 3mg IV push every 3 months over 15-30 seconds
- Prolia 60mg Sub-Q every 6 months

BMP or baseline Ca2+

Pre-term Birth:

- Makena 250mg IM weekly (Please complete manufacturers referral form)

Other Medication Orders:

- Anaphylaxis Kit

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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