Human Immunodeficiency Virus Enrollment Form

TwelveStone Health Partners
Fax Referral To:
(800) 223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

Date: _____
Patient Name: _____
Date of Birth: _____

PREVIOUS ADMINISTRATION

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last Injection Date: _____ Next Injection Date: _____	☐ Physician's Office ☐ TwelveStone Infusion Center ☐ Home Administration ☐ Pharmacy to Schedule Injection ☐ Other: _____ Desired Start Date: _____

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

DIAGNOSIS

Description:	***ICD-10 Code:***
Secondary Endocrine Diagnosis Description:	***Secondary Endocrine Diagnosis 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 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: _____

Specific Lab Results – CD4 Count:_____ Viral Load:_____ Scr:_____

Previous Antiretroviral Therapy:

Medication & Dosage	Date Range of Therapy	Reason for Discontinuation

MEDICATION

Combination Products			NRTI	NNRTI	Protease Inhibitors	MISC.
☐ Atripla	☐ Epzicom	☐ Stribild	☐ Emtriva	☐ Edurant	☐ Aptivus	☐ Fuzeon
☐ Biktarvy	☐ Evotaz	☐ Symfi	☐ Epivir	☐ Intelence	☐ Invirase	☐ Trogarzo
☐ Cimduo	☐ Genvoya	☐ Symfi Lo	☐ Retrovir	☐ Pifeltro	☐ Lexiva	☐ Prezcobix
☐ Combivir	☐ Juluca	☐ Symtuza	☐ Videx EC	☐ Rescriptor	☐ Norvir	☐ Selzentry
☐ Complera	☐ Kaletra	☐ Triumeq	☐ Viread	☐ Sustiva	☐ Prezista	☐ Tybost
☐ Descovy	☐ Odefsey	☐ Trizivir	☐ Zerit	☐ Viramune	☐ Crixivan	☐ Isentress
☐ Delstrigo	☐ Prezcobix	☐ Truvada	☐ Ziagen	☐ Viramune XR	☐ Reyataz	☐ Tivicay

☐ Other Therapy(s) than Listed Above: _____

Dose:_____ Quantity:_____ Refills:_____

Directions:

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone Number | Physician's NPI | Physician's Fax | Physician's Address

Dispense as Written | Date | Substitution Allowed | Date