Human Growth Hormone Therapy 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: _____

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: _____

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

MEDICATION	DOSAGE FORM	DIRECTIONS	QUANTITY	REFILLS
☐ Humatrope	Pen: ☐6mg ☐12mg ☐24mg	Inject _____mg Subcutaneously _____ days/week		0
	PFS: ☐6mg ☐12mg ☐24mg			0
	Vial: ☐5mg			0
☐ Norditropin	Flexpro: ☐5mg ☐10mg ☐15mg	Inject _____mg Subcutaneously _____ days/week		0
	PF Pen: ☐30mg/3ml			0
☐ Saizen	Click Easy Device: ☐8.8mg	Inject _____mg Subcutaneously _____ days/week		0
	Vial: ☐5mg ☐ 8.8mg			0
☐ Genotropin	Pen: ☐5mg ☐12mg	Inject _____mg Subcutaneously _____ days/week		0
	Mini Quick: ☐0.2mg ☐0.4mg ☐0.6mg ☐0.8mg ☐1.0mg ☐1.2mg ☐1.4mg ☐1.6mg ☐1.8mg ☐2.0mg			0
☐ Serostim	Cartridges: 6mg	Inject _____mg Subcutaneously _____ days/week		0
☐ Omnitrope	Pen: ☐5mg ☐10mg	Inject _____mg Subcutaneously _____ days/week		0
	Vial: ☐5.8ml			0
☐ Zorbtive	Vial: 8.8mg	Inject _____mg Subcutaneously _____ days/week		0
☐ Nutropin AQ	Nuspin: ☐5mg ☐10mg ☐20mg	Inject _____mg Subcutaneously _____ days/week		0
	Vial: ☐10mg			0
☐ Lupron Depot PED	PFS: ☐7.5mg ☐11.25mg ☐15mg	Inject Intramuscularly once a month		0

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

Physician's Phone#	Physician's NPI#	Physician's Fax#	Physician' Address
Dispense as Written	Printed Name	Substitution Allowed	Date