Women's Health Therapy Enrollment Form

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

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

PREVIOUS ADMINISTRATION

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last Infusion Date: _____ Next Infusion Date: _____	☐ 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 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
Osteoporosis: ☐ Forteo Pen 20mcg SQ daily ☐ Tymlos Pen 80mcg SQ daily ☐ Zoledronic Acid 5mg IV over 15 minutes every year(s) ☐ Prolia 60mg Sub-Q every 6 months	BMP
Pre-term Birth: ☐ Makena 250mg IM weekly (Please complete manufacturers referral form) ☐ Makena 275mg/1.1ml Subcutaneous AutoInjector	
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.

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