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
email: intake@12stonehealth.com

PREVIOUS ADMINISTRATION

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last Infusion Date: ______________	☐ Physician's Office
Next Infusion Date: ______________	☐ TwelveStone Infusion Suite
	☐ 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
Pre-term Birth: ☐ Hydroxyprogesterone 250mg IM weekly ☐ Makena 275mg SQ Auto-injector	
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 ☐ Orlissa ____mg by mouth ____ times daily for _____ months	
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 ☐ Diclegis _____mg by mouth daily	
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 ☐ Evenity 210mg (2 syringes - 105mg/syringe) Sub-Q every month ☐ Pen needles ____ Gauge	BMP or baseline Ca2+
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
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)	
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	Date	Substitution Allowed	Date

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