Hepatology Enrollment Form - Page 1 of 2

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

TwelveStone HEALTH PARTNERS

PREVIOUS ADMINISTRATION

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last Dosing Date: _____	☐ Physician's Office
Next Dosing Date: _____	☐ Home Administration
	☐ Other: _____
	Desired Start Date: _____

DIAGNOSIS

Description:	*ICD-10 Code:*
☐ Chronic Hepatitis B ☐ Hepatic Encephalopathy	☐ B19.10 ☐ K72
☐ Chronic Hepatitis C	☐ B18.2

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 – HCV Viral Load: _____ Genotype: _____ Subtype: _____ Degree of Fibrosis: _____ Polymorphism: _____ CKD Stage: _____

Co-Infection? ☐ HBV ☐ HIV Pertinent HBV serologies (if applicable) _____ Scr: _____ Date _____

Previous Hepatitis Therapy(s):

Medication & Dosage	Date Range of Therapy	Reason for Discontinuation

MEDICATION	DOSE	DIRECTIONS	Refills	LAB & ANCILLARY ORDERS
☐ Baraclude	☐ 0.5mg tablet	Take 0.5mg daily on an empty stomach. Take at least 2 hours after a meal & 2 hours before a meal.		
	☐ 1mg tablet	Take 1mg daily on an empty stomach. Take at least 2 hours after a meal & 2 hours before a meal.		
	☐ 0.5 mg/ml oral suspension	Take____ml (____mg) daily on an empty stomach. Take at least 2 hours after a meal & 2 hours before a meal.		
☐ Epivir HBV	☐ 100mg tablet	☐ Take 100mg daily		
	☐ 5mg/ml oral suspension	☐ Take_____ml (_____mg) _____times daily		
☐ Viread	☐ 300mg tablet	Take____ mg by mouth every ___ hours		
	☐ 250mg tablet			
	☐ 200mg tablet			
	☐ 150mg tablet			
	☐ 40mg/gm oral powder	Take____ scoops daily mixed with 2-4 ounces of soft food		
☐ Hepsera	10mg tablet	Take 10mg by mouth every__ hours/days		
☐ Xifaxan	☐ 550mg tablet	☐ Take 1 tablet by mouth twice daily		
		☐ Take 1 tablet by mouth three times daily for 14 days		
	☐ 200mg tablet	☐ Take 1 tablet by mouth three times daily for 3 days		
☐ Vemildy	☐ 25mg tablet	Take one tablet by mouth daily with food		
☐ Epclusa	400mg/100mg tablet	Take one tablet by mouth daily for 12 weeks	2	
☐ Harvoni	90mg/400mg tablet	Take one tablet by mouth daily		
☐ Mavyret	100mg/40mg tablet	Take 3 tablets by mouth once daily		
☐ Ribavirin	200mg tablet	Take_____mg by mouth every morning, and ____mg by mouth every evening (_____mg/day)		

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MEDICATION	DOSE	DIRECTIONS	REFILLS	LAB & ANCILLARY ORDERS
☐ Sovaldi	400mg tablet	Take one tablet by mouth daily		
☐ Vosevi	400mg/100mg/100mg	Take one tablet by mouth daily		
☐ Zepatier	50mg/100mg	Take one tablet by mouth daily		

☐ 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)
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 Number	Physician's NPI	Physician's Fax	Physician's Address
Prescriber Name/Group	Dispense as Written	Substitution Allowed	Date