Urology Therapy—Enrollment Form

Date: ______________________

Patient Name: ______________________

Date of Birth: ______________________

Diagnosis Date: ______________________

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:

Last injection date: ______________________

Next injection date: ______________________

If **NO**, please indicate desired location for first dose:

☐ Physician's office
☐ TwelveStone Infusion Center
☐ TwelveStone Home Infusion
☐ Enroll in Manufacturer Nurse Training

Desired start date: ______________________

DIAGNOSIS—ICD-10 CODE

☐ Overactive Bladder—N32.81
☐ Prostate Cancer—C61
☐ Peyronie's Disease—N48.6
☐ Bone Metastasis—C79.51
☐ Prolonged Androgen Therapy—Z79.818
☐ Other/Supporting Diagnosis—ICD-10: __________

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed.)

☐ This signed order form
☐ History and Physical
☐ TB and Hep B Documentation
☐ Patient Demographics and Insurance Information
☐ Clinic 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 BSA: __________ Allergies: __________

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ Botox	☐ 100 Unit Vial ☐ 200 Unit Vial	Inject ________ units into ____________ every ______ days		
☐ Eligard	☐ 7.5mg Kit ☐ 22.5mg Kit ☐ 30mg Kit ☐ 45mg Kit	☐ Inject 7.5mg IM every month ☐ Inject 22.5mg IM every 3 months ☐ Inject 30mg IM every 4 months ☐ Inject 45mg IM every 6 months		
☐ Firmagon	☐ 240mg Starter (2 Vials of 120mg each) ☐ 80mg Vial	Initiation—240mg SQ x 1 dose (2 injections of 120mg), then 28 days later begin maintenance dosing Maintenance—Inject 80mg SQ every 28 days		
☐ Lupron	☐ 7.5 mg Kit ☐ 22.5mg Kit ☐ 30mg Kit ☐ 45mg Kit	☐ Inject 7.5mg IM every 4 weeks ☐ Inject 22.5mg IM every 12 weeks ☐ Inject 30mg IM every 16 weeks ☐ Inject 45mg IM every 24 weeks		
☐ Prednisone	☐ 5mg Tablet	☐ Take 5mg by mouth once daily ☐ Take 5mg by mouth twice daily		
☐ Prolia	☐ 60mg PFS	Inject 60mg SQ every 6 months into upper arm, upper thigh, or abdomen		

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

Physician's Phone: ______________ Fax: ______________

Physician's NPI: ______________________

Physician's Address: ______________________

____

Substitution Allowed: ______________________

Dispense as Written: ______________________

Printed Name: ______________________

Date: ______________________

*By signing this form and utilizing our services, you are authorizing TwelveStone Health Partners™ and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies. **IMPORTANT NOTICE:** This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.*

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MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ Trelstar	☐ 3.75mg ☐ 11.25mg ☐ 22.5mg	☐ Inject 3.75mg IM every 4 weeks ☐ Inject 11.25mg IM every 12 weeks ☐ Inject 22.5mg IM every 24 weeks		
☐ Testosterone Cypionate	☐ 200mg/ml Vial	Inject __________ mg IM every __________ week(s)		
☐ TICE BCG	☐ 50mg Vial	☐ Initiation—Administer via intravesical route once weekly for 6 weeks ☐ Maintenance—Administer via intravesical route once monthly for ____ months		
☐ Xgeva	☐ 120mg/1.7ml Vial	Inject 120mg SQ every 4 weeks with additional doses on days 8 and 15 of the first month of therapy		
☐ Xiaflex	☐ 0.9mg Vial	Inject 0.58mg into penile plaque 2 times (1-3 days apart) at approximately 6 week intervals for up to 4 cycles	2 Vials	
☐ Xtandi	☐ 40mg Capsule	Take four capsules (160mg) by mouth once daily		
☐ Zytiga	☐ 250mg Tablet ☐ 500mg Tablet	☐ Take 4 tablets (1000mg) by mouth once daily on empty stomach ☐ Take 2 tablets (1000mg) by mouth once daily on empty stomach		

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

Physician's Phone: ______________________ Fax: ______________________

Physician's NPI: ______________________

Physician's Address: ______________________

____

Substitution Allowed: ______________________

Dispense as Written: ______________________

Printed Name: ______________________

Date: ______________________

*By signing this form and utilizing our services, you are authorizing TwelveStone Health Partners™ and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies. **IMPORTANT NOTICE:** This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.*