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

Please ship to: ☐ Patient ☐ Physician/clinic ☐ 1st dose to Physician/clinic, remaining refills to patient

Patient's Address: ____

OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)

☐ This signed order form ☐ History and Physical ☐ Ultrasound report (Makena, hydroxyprogesterone)

☐ 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: ____________________

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
Pre-term Birth: ☐ Makena ☐ O09.212 ☐ O09.213 ☐ O09.219 ☐ Other: ☐ Hydroxyprogesterone	☐ 275mg/1.1ml Auto-Injector pen ☐ 250mg/ml vial	☐ Inject 1.1ml SQ every 7 days ☐ Inject 1ml IM every 7 days	☐ 4 auto-injectors ☐ 4 vials	Refill up to 37 weeks
Endometriosis/Uterine Fibroid: ☐ Lupron	☐ 3.75mg kit ☐ 11.25mg kit	☐ Administered IM once a month ☐ Administered IM once every 3 months	☐ 1 kit (1-month supply) ☐ 1 kit (3-month supply)	
☐ Lupaneta Pack	☐ 3.75mg kit/5mg norethindrone tablets ☐ 11.25mg kit/5mg norethindrone tablets	☐ Administer Lupron IM once a month; take one norethindrone tablet by mouth daily ☐ Administer Lupron IM every 3 months; take one norethindrone tablet by mouth daily	☐ 1 kit (1-month supply) ☐ 1 kit (3-month supply)	
☐ Norethindrone	☐ 5mg tablets	☐ Take one tablet by mouth daily		
☐ Orlissa	☐ 150mg tablet ☐ 200mg tablet	☐ Take one tablet by mouth daily ☐ Take one tablet by mouth twice daily		
Osteoporosis: ☐ Evenity	☐ 105mg/1.17ml PFS	☐ Administer 210mg (2 consecutive injections of 105mg each) SQ once monthly for 12 doses	☐ 2 PFS	11
☐ Forteo Pen	☐ 600mcg/2.4ml pen ☐ BD pen needles 31G x 5mm ☐ BD pen needles 31G x 8mm	☐ Inject 20mcg (0.08ml) SQ once daily ☐ Use as directed with Forteo ☐ Use as directed with Forteo	☐ 1 pen (28 day supply)	
☐ Prolia	☐ 60mg PFS	☐ Inject 60mg SQ every 6 months	☐ 1 PFS	
Other Medication Orders: ☐ Gardasil 9 Vaccine	☐ 0.5ml PFS	☐ Inject 0.5ml IM once at 0, 2, and 6 months	1 PFS	

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 Fax# : ____________________

Dispense as Written: ____________________

Substitution Allowed: ____________________

Physician's NPI#: ____________________

Physician's Address: ____________________

Printed Name: ____________________

Date: ____________________

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