

Urology Therapy Enrollment Form

TwelveStone Health Partners



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

Description

- Overactive Bladder--N32.81
- Peyronie's Disease--N48.6
- Prolonged Androgen Therapy--Z79.818

- Prostate Cancer--C61
- Bone Metastasis--C79.51
- Other/Supporting Diagnosis: _____

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
- 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 BSA: _____ Allergies: _____

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Botox	<input type="checkbox"/> 100 Unit Vial <input type="checkbox"/> 200 Unit Vial	Inject _____ units into _____ every _____ days		
<input type="checkbox"/> Eligard	<input type="checkbox"/> 7.5 mg Kit <input type="checkbox"/> 22.5 mg Kit <input type="checkbox"/> 30 mg Kit <input type="checkbox"/> 45 mg Kit	<input type="checkbox"/> Inject 7.5mg IM every month <input type="checkbox"/> Inject 22.5mg IM every 3 months <input type="checkbox"/> Inject 30mg IM every 4 months <input type="checkbox"/> Inject 45mg IM every 6 months		
<input type="checkbox"/> Firmagon	<input type="checkbox"/> 240mg Starter (2 vials of 120mg each) <input type="checkbox"/> 80mg Vial	<input type="checkbox"/> Initiation—240mg SQ x 1 dose (2 injections of 120mg), then 28 days later (2 Vials of 120mg each) begin maintenance dosing <input type="checkbox"/> Maintenance – Inject 80mg SQ every 28 days		
<input type="checkbox"/> Lupron	<input type="checkbox"/> 7.5 mg Kit <input type="checkbox"/> 22.5 mg Kit <input type="checkbox"/> 30 mg Kit <input type="checkbox"/> 45 mg Kit	<input type="checkbox"/> Inject 7.5mg IM every 4 weeks <input type="checkbox"/> Inject 22.5mg IM every 12 weeks <input type="checkbox"/> Inject 30mg IM every 16 weeks <input type="checkbox"/> Inject 45mg IM every 24 weeks		
<input type="checkbox"/> Prednisone	5mg Tablet	<input type="checkbox"/> Take 5mg by mouth once daily <input type="checkbox"/> Take 5mg by mouth twice daily		
<input type="checkbox"/> 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: _____ Physician's NPI: _____

Dispense as written: _____ Date: _____

Physician's Fax: _____ Physician's Address: _____

Printed name: _____ Substitution allowed: _____

The information contained in this facsimile may be confidential and is intended solely for the use of the named recipient(s). Access, copying or re-use of the facsimile or any information contained therein by any other person is not authorized. If you are not the intended recipient, please notify us immediately by calling 615-895-0186 or faxing back to the originator.

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MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Trelstar	<input type="checkbox"/> 3.75mg <input type="checkbox"/> 11.25mg <input type="checkbox"/> 22.5mg	<input type="checkbox"/> Inject 3.75mg IM every 4 weeks <input type="checkbox"/> Inject 11.25mg IM every 12 weeks <input type="checkbox"/> Inject 22.5mg IM every 24 weeks		
<input type="checkbox"/> TICE BCG	50mg vial	<input type="checkbox"/> Initiation - Administer via intravesical route once weekly for 6 weeks <input type="checkbox"/> Maintenance - Administer via intravesical route once monthly for ___ months		
<input type="checkbox"/> Xgeva	120mg/1.7ml Vial	Inject 120mg SQ every 4 weeks with additional doses on day 8 and 15 of the first month of therapy		
<input type="checkbox"/> Xiaflex	0.9mg Vial	Inject 0.58 mg into penile plaque 2 times (1-3 days apart) at approximately 6 week intervals for up to 4 cycles	2 vials	
<input type="checkbox"/> Xtandi	40mg Capsule	Take four capsules (160mgs) by mouth once daily		
<input type="checkbox"/> Zytiga	<input type="checkbox"/> 250mg Tablet <input type="checkbox"/> 500mg Tablet	<input type="checkbox"/> Take 4 tablets (1000mg) by mouth once daily with prednisone <input type="checkbox"/> Take 2 tablets (1000mg) by mouth once daily with prednisone		

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