Human Immunodeficiency Virus 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

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
- ☐ Home Administration
- ☐ Pharmacy to Schedule Injection
- ☐ Other: ______________________

Desired Start Date: ______________________

☐ Patient has received injection training ☐ Physician's office to provide injection training ☐ TwelveStone Health Partners to arrange injection

DIAGNOSIS

Description:	***ICD-10 Code:***
Secondary Endocrine Diagnosis Description:	***Secondary Endocrine Diagnosis 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 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 – CD4 Count:__________________________ Viral Load:____________________________ Scr:____

Previous Antiretroviral Therapy:

Medication & Dosage	Date Range of Therapy	Reason for Discontinuation

MEDICATION

Combination Products			**NRTI**	**NNRTI**	**Protease Inhibitors**	**MISC.**
☐ Atripla	☐ Epzicom	☐ Stribild	☐ Emtriva	☐ Edurant	☐ Aptivus	☐ Fuzeon
☐ Biktarvy	☐ Evotaz	☐ Symfi	☐ Epivir	☐ Intelence	☐ Invirase	☐ Trogarzo
☐ Cimduo	☐ Genvoya	☐ Symfi Lo	☐ Retrovir	☐ Pifeltro	☐ Lexiva	☐ Prezcobix
☐ Combivir	☐ Juluca	☐ Symtuza	☐ Videx EC	☐ Rescriptor	☐ Norvir	☐ Selzentry
☐ Complera	☐ Kaletra	☐ Triumeq	☐ Viread	☐ Sustiva	☐ Prezista	☐ Tybost
☐ Descovy	☐ Odefsey	☐ Trizivir	☐ Zerit	☐ Viramune	☐ Crixivan	☐ Isentress
☐ Delstrigo	☐ Prezcobix	☐ Truvada	☐ Ziagen	☐ Viramune XR	☐ Reyataz	☐ Tivicay

☐ 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)

Physician's Phone Number	Physician's NPI	Physician's Fax	Physician's Address
Dispense as Written	Date	Substitution Allowed	Date

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