Urology Therapy Enrollment Form

Date: _____

Patient Name: _____

Date of Birth: _____

Diagnosis Date: _____

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:	If NO, please indicate desired location for first dose:
Last injection date: _____ Next injection date: _____	☐ 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
☐ Botox	☐ 100 Unit Vial ☐ 200 Unit Vial	Inject _____units into _____every _____days		
☐ Eligard	☐ 7.5 mg Kit ☐ 22.5 mg Kit ☐ 30 mg Kit ☐ 45 mg 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 (2 Vials of 120mg each) begin maintenance dosing ☐ Maintenance – Inject 80mg SQ every 28 days		
☐ Lupron	☐ 7.5 mg Kit ☐ 22.5 mg Kit ☐ 30 mg Kit ☐ 45 mg 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:_____ Physician's NPI:_____	Dispense as written: _____ Date: _____
Physician's Fax: _____ Physician's Address: _____	Printed name: _____ Substitution allowed:_____

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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		
☐ 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 day 8 and 15 of the first month of therapy		
☐ 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	
☐ Xtandi	40mg Capsule	Take four capsules (160mgs) by mouth once daily		
☐ Zytiga	☐ 250mg Tablet ☐ 500mg Tablet	☐ Take 4 tablets (1000mg) by mouth once daily with prednisone ☐ Take 2 tablets (1000mg) by mouth once daily with prednisone		

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Physician's Fax: _____ Physician's Address: _____	Printed name: _____ Substitution allowed:_____