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:	☐ 275mg/1.1ml Auto-Injector pen	☐ Inject 1.1ml SQ every 7 days	☐ 4 auto-injectors	Refill up to 37 weeks
☐ Hydroxyprogesterone	☐ 250mg/ml vial	☐ Inject 1ml IM every 7 days	☐ 4 vials	
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	☐ Administer Lupron IM once a month; take one norethindrone tablet by mouth daily	☐ 1 kit (1-month supply)	
	☐ 11.25mg kit/5mg norethindrone tablets	☐ Administer Lupron IM every 3 months; take one norethindrone tablet by mouth daily	☐ 1 kit (3-month supply)	
☐ Norethindrone	☐ 5mg tablets	☐ Take one tablet by mouth daily		
☐ Orlissa	☐ 150mg tablet	☐ Take one tablet by mouth daily		
	☐ 200mg tablet	☐ 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 NPI#: _____

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

Dispense as Written: _____ Printed Name: _____

Substitution Allowed: _____ Date: _____