Hepatology (A-S)
Enrollment Form Page 1 of 2

Date: ______________________

Patient Name: ______________________

Date of Birth: ______________________

TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

TwelveStone HEALTH PARTNERS™

DIAGNOSIS

☐ B19.0 Chronic Hepatitis B ☐ B18.2 Chronic Hepatitis C ☐ K76.82 Hepatic Encephalopathy
☐ Other: ______________________

Ship To: ☐ Physician's Office ☐ Patient's Home ☐ Other: ______________

CLINICAL INFORMATION & OTHER REQUIRED DOCUMENTATION- *(Please attach documents as needed)*

☐ History and Physical
☐ This Signed Order Form
☐ Prior Failed Medication: ______________________
☐ Patient Demographics and Insurance Information
☐ Clinical Progress Notes, Relevant Labs with dates, etc.

Patient Weight: ________ Kg/Lbs Patient Height: ________ Inches/CM Allergies: ______________

HCV Viral Load: ______________ Genotype: ________ Fibrosis Score: __________ Compensated ________ Decompensated ________

Cirrhosis: YES ____ NO ____ Polymorphism: ________ CKD Stage: ________

Co-Infection: ____ HBV ____ HIV Treatment Naive: YES ____ NO ____ If NO, Please list Previous Hepatitis Therapy Below:

Medication & Dosage:	Date Range of Therapy:	Reason for Discontinuation:

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ BARACLUDE	☐ 0.5mg Tablet	Take 0.5mg daily on an empty stomach. Take at least 2 hours after a meal & 2 hours before next meal		
	☐ 1mg Tablet	Take 1mg daily on an empty stomach. Take at least 2 hours after a meal & 2 hours before next meal		
	☐ 0.05mg/ml Oral Solution	Take ____ml(____mg) daily on an empty stomach. Take at least 2 hours after a meal & 2 hours before next meal		
☐ EPCLUSA	☐ 400mg/100mg Tablet	Take one tablet by mouth daily for 12 weeks		2
☐ EPIVIR HBV	☐ 100mg Tablet	Take 100mg daily		
	☐ 5mg/ml Oral Solution	Take ____ml(____mg) once daily		
☐ HARVONI	☐ 90mg/400mg Tablet	Take 1 tablet by mouth daily		
☐ HEPSERA	☐ 10mg Tablet	Take 1 tablet by mouth daily Other: ______________________		
☐ MAVYRET	☐ 100mg/40mg Tablet	Take 3 tablets by mouth once daily		
☐ RIBVIRIN	☐ 200mg Tablet	Take ________ mg by mouth every morning, and ________ mg by mouth every evening (________ mg/day)		
☐ SOVALDI	☐ 400mg Tablet	Take 1 tablet by mouth daily		

☐ Other Therapy(s) than Listed Above: ______________________

Dose: ______________ Quantity: ______________ Refills: ______________

Directions: ______________________

By signing below, I certify that the 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 Number ______________ Physician's NPI ______________ Physician's Fax ______________ Physician's Address

______________ Prescriber Name/Group ______________ Dispense as Written ______________ Substitution Allowed ______________ Date

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Hepatology (V-Z)
Enrollment Form Page 2 of 2

Date: ______________________

Patient Name: ______________________

Date of Birth: ______________________

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☐ Other: ______________________

Ship To: ☐ Physician's Office ☐ Patient's Home ☐ Other: ______________

CLINICAL INFORMATION & OTHER REQUIRED DOCUMENTATION- *(Please attach documents as needed)*

☐ History and Physical
☐ This Signed Order Form
☐ Prior Failed Medication: ______________________
☐ Patient Demographics and Insurance Information
☐ Clinical Progress Notes, Relevant Labs with dates, etc.

Patient Weight: ________ Kg/Lbs Patient Height: ________ Inches/CM Allergies: ______________

HCV Viral Load: ______________ Genotype: ________ Fibrosis Score: __________ Compensated ________ Decompensated ________

Cirrhosis: YES ____ NO ____ Polymorphism: ________ CKD Stage: ________

Co-Infection: ____ HBV ____ HIV Treatment Naive: YES ____ NO ____ If NO, Please list Previous Hepatitis Therapy Below:

Medication & Dosage:	Date Range of Therapy:	Reason for Discontinuation:

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ VEMLIDY	☐ 25mg Tablet	Take 1 tablet by mouth daily with food		
☐ VIREAD	☐ 300mg Tablet ☐ 250mg Tablet ☐ 200mg Tablet ☐ 150mg Tablet	Take ____mg by mouth every ____ hours		
	☐ 40mg/gm Oral Powder	Take ____ scoops daily mixed with 2-4 ounces of soft food		
☐ VOSEVI	☐ 400mg/100mg/100mg	Take 1 tablet by mouth daily with food		
☐ XIFAXAN	☐ 550mg Tablet	☐ Take 1 tablet by mouth twice daily ☐ Take 1 tablet by mouth three times daily for 14 days		
	☐ 200mg Tablet	Take 1 tablet by mouth three times daily for 3 days		
☐ ZEPATIER	☐ 50mg/100mg	Take 1 tablet by mouth daily		

☐ Other Therapy(s) than Listed Above: ______________________

Dose: ______________ Quantity: ______________ Refills: ______________

Directions: ______________________

By signing below, I certify that the 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 Number ______ Physician's NPI ______ Physician's Fax ______ Physician's Address ______

Prescriber Name/Group ______ Dispense as Written ______ Substitution Allowed ______ Date ______

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