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

Date: ______________________

Patient Name: ______________________

Date of Birth: ______________________

TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: intake@12stonehealth.com

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, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

______________	______________	______________	______________
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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☐ History and Physical
☐ This Signed Order Form
☐ Prior Failed Medication: ____________________
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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: ____________________

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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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