Human Growth Hormone Therapy Enrollment Form

Date: _____

Patient Name: _____

Date of Birth: _____

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com

CLINICAL INFORMATION

Weight: _____ lbs OR _____ kg Height: _____ in OR _____ cm Drug Allergies: _____

DIAGNOSIS

Description:	*ICD-10 Code:*
Secondary Endocrine Diagnosis Description:	*Secondary Endocrine Diagnosis ICD-10 Code:*

Is the patient currently on therapy? _____**Yes** _____**No**

Last Injection Date: _____

Next Injection Date: _____

OTHER REQUIRED DOCUMENTATION (Please attach as needed)

- ☐ This Signed Order Form
- ☐ History and Physical
- ☐ Patient Demographics and Insurance Infomarion
- ☐ Clinical progress notes, lab work (including any necessary supportive documentation for HGH therapy)

DELIVER TO:

- ☐ Physician's Office
- ☐ Patient's Home
- ☐ TwelveStone Infusion Center
- ☐ Pharmacy to Schedule Injection
- ☐ Other: _____

TRAINING:

- ☐ Patient Has Received Injection Training
- ☐ Physician's Office to Provide Injection Training
- ☐ Pharmacy to Coordinate Injection Training

Desired Start Date: _____

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ GENOTROPIN	Pen: ☐ 5mg ☐ 12mg Mini Quick: ☐ 0.2mg ☐ 0.4mg ☐ 0.6mg ☐ 0.8mg ☐ 1.0mg ☐ 1.2mg ☐ 1.4mg ☐ 1.6mg ☐ 1.8mg ☐ 2.0mg	Inject _____ mg Subcutaneously _____ days/week		
☐ HUMATROPE	Pen: ☐ 6mg ☐ 12mg ☐ 24mg PFS: ☐ 6mg ☐ 12mg ☐ 24mg Vial: ☐ 5mg	Inject _____ mg Subcutaneously _____ days/week		
☐ LUPRON DEPOT PED	PFS: ☐ 7.5mg ☐ 11.25mg ☐ 15mg	Inject intramuscularly once a month		
☐ NORDITROPIN	Flexpro: ☐ 5mg ☐ 10mg ☐ 15mg PF Pen: ☐ 30mg/3ml	Inject _____ mg Subcutaneously _____ days/week		
☐ NUTROPIN AQ	Nuspin: ☐ 5mg ☐ 10mg ☐ 20mg Vial: ☐ 10mg	Inject _____ mg Subcutaneously _____ days/week		
☐ OMNITROPE	Pen: ☐ 5mg ☐ 10mg Vial: ☐ 5.8mg	Inject _____ mg Subcutaneously _____ days/week		
☐ SAIZEN	Click Easy Device: ☐ 8.8mg Vial: ☐ 5mg ☐ 8.8mg	Inject _____ mg Subcutaneously _____ days/week		
☐ SEROTOSIM	Cartirdges: 6mg	Inject _____ mg Subcutaneously _____ days/week		
☐ ZORBTIVE	Vial: 8.8mg	Inject _____ mg Subcutaneously _____ days/week		

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 Number

_____ Physician's Address

_____ Dispense as Written:

_____ Printed Name:

_____ Substitution Allowed:

_____ Date: