Human Immunodeficiency Virus 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: _____

☐ Specific Lab Results-CD4 Count: _____ Viral Load: _____ Scr: _____

☐ Previous Antiretroviral Therapy: _____

Medication & Dosage	Date Range of Therapy	Reason for Discontinuation

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

☐ Patient Demographics and Insurance Infomarion

☐ History and Physical

☐ 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

Combination Products		NRTI	NNRTI	PROTEASE INHIBITORS	MISC.
☐ ATRIPLA	☐ KALETRA	☐ EMTRIVA	☐ EDURANT	☐ APTIVUS	☐ FUZEON
☐ BIKTARVY	☐ ODEFSEY	☐ EPIVIR	☐ INTELENCE	☐ INVIRASE	☐ TROGARZO
☐ CIMDUO	☐ PREZCOBIX	☐ RETROVIR	☐ PIFELTRO	☐ LEXIVA	☐ PREZOBIX
☐ COMBIVIR	☐ STRIBILD	☐ VIDEX EC	☐ RESCRIPTOR	☐ NORVIR	☐ SELZENTRY
☐ COMPLERA	☐ SYMFI	☐ VIREAD	☐ SUSTIVA	☐ PREZISTA	☐ TYBOST
☐ DESCOVY	☐ SYMFI LO	☐ ZERIT	☐ VIRAMUNE	☐ CRIXIVAN	☐ ISENTRESS
☐ DELSTRIGO	☐ SYMTUZA	☐ ZIAGEN	☐ VIRAMUNE XR	☐ REYATAZ	☐ TRIVICAY
☐ EPZICOM	☐ TRUMEQ				
☐ EVOTAZ	☐ TRIZIVIR				
☐ GENVOYA	☐ TRUVADA				
☐ JULUCA					

☐ 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 Number	Physician's Address
Dispense as Written:	Printed Name:	Substitution Allowed:	Date: