LINDEN RETAIL SPECIALTY PHARMACY

ACROMEGALY ENROLLMENT FORM

Phone: 908-583-6665 | Fax: 888-474-0976

Email: lindensprx@gmail.com

SIX SIMPLE STEPS TO SUBMITTING A REFERRAL

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name _____ Address _____ City, State, ZIP _____

Preferred Contact Methods ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone _____ Alternate Phone _____ Date of Birth _____ Gender ◯ Male ◯ Female

Email _____ Last Four of SSN _____ Primary Language _____

2 PRESCRIBER INFORMATION

Prescriber's Name _____ State License Number _____

NPI Number _____ DEA Number _____ Group or Hospital _____

Address _____ City, State, ZIP _____

Phone _____ Fax _____ Contact Person _____ Contact's Phone _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date _____ Ship to ☐ Patient ☐ Office ☐ Other _____

Diagnosis (ICD-10):

☐ E22.0 acromegaly and pituitary giantism ☐ Other Code _____ Description _____

Patient Clinical Information

Allergies _____ Height _____ in/cm Weight _____ lb/kg

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Sandostatin Injection Ampules	☐ 50 mcg/ml ☐ 100 mcg/ml ☐ 500 mcg/ml	☐ Administer _____ mcg SC three times a day. ☐ Other: _____	Quantity _____ Refills _____
☐ Sandostatin Injection Multi-dose Vials	☐ 200 mcg/ml (5 ml) ☐ 1,000 mcg/ml (5 ml)	☐ Administer _____ mcg SC three times a day. ☐ Other: _____	Quantity _____ Refills _____
☐ Sandostatin LAR Depot	☐ 10 mg vial kit ☐ 20 mg vial kit ☐ 30 mg vial kit	☐ Mix the contents of one vial with diluent and administer intragluteally every 4 weeks ☐ Other: _____	Quantity ☐ 4-week supply ☐ 12-week supply Refills _____
☐ Somatuline Depot	☐ 60 mg prefilled syringe ☐ 90 mg prefilled syringe ☐ 120 mg prefilled syringe	☐ Inject 90 mg (1 syringe) SC every 4 weeks ☐ Other: Inject _____ mg (1 syringe) SC every 4 weeks	Quantity ☐ 4-week supply ☐ 12-week supply Refills _____
☐ Somavert	☐ 10 mg vial ☐ 15 mg vial ☐ 20 mg vial ☐ 25 mg vial ☐ 30 mg vial	☐ Inject _____ mg SC once daily ☐ Other: _____	Quantity ☐ _____ 10 mg vial kits ☐ _____ 15 mg vial kits ☐ _____ 20 mg vial kits Refills _____

Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** **Ancillary supplies and kits provided as needed for administration**

6 PHYSICIAN SIGNTURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED _____ (DATE) _____ DISPENSE AS WRITTEN _____ (DATE) _____