

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 SIGNATURE REQUIRED

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

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