Acromegaly Injection
REFERRAL FORM

FAX REFERRAL TO: +1(844) 277-0049 **PHONE:** +1(844) 650-5802

IV Solutions RX

1 PATIENT'S INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ **DOB:** _____ **Gender:** ☐ MALE ☐ FEMALE
Address: _____ **City/State/Zip:** _____
Primary Phone: _____ **Email:** _____ **SSN:** _____ **Primary Language:** _____
Emergency Contact: _____ **Relationship to Patient:** _____ **Phone:** _____

2 INSURANCE *(Please attach **If Available** a copy of the Patients' insurance card(s) Front/ Back)*

Primary Insurance: _____ **Policy No:** _____ **Group:** _____
Primary RX Insurance: _____ **ID No:** _____ **RX GRP:** _____ **RX BIN:** _____ **RX PCN:** _____

3 DIAGNOSIS AND CLINICAL INFORMATION

First time receiving Immunoglobulin Therapy? ☐ Yes ☐ No **If No, previous product used:** _____ **Last Dose Given:** _____

Patient Clinical Information:

Drug Allergies: _____ ☐ NKDA **Ht:** _____ in/cm **Wt:** _____ lbs/Kg

Diagnosis (ICD-10):

☐ C7A.1 Malignant poorly differentiated neuroendocrine tumors ☐ E22.0 Acromegaly and pituitary gigantism

☐ Other: _____ Description: _____

Labs: Please fax copy of the following labs dated within 1 year of the patients referral request: ☐ **CMP** ☐ **CBC w/ diff**

4 PRESCRIPTION INFORMATION

Access: ☒ Subcutaneous

MEDICATION	STRENGTH	DOSE & DIRECTION	QUANTITY	REFILL
☐ **Lanreotide**	☐ 60mg/0.2mL PFS ☐ 90mg/0.3mL PFS ☐ 120mg/0.5mL PFS	Administer 1 injection subcutaneously every 28 days. Skilled Nursing Visit PRN for administration.	Quantity: **(X1) Syringe**	Refills: _____
☐ **SANDOSTATIN LAR DEP** ☐ **octreotide acetate LAR**	☐ 10 mg Vial ☐ 20 mg Vial ☐ 30 mg Vial	Administer 1 injection subcutaneously every 28 days. Skilled Nursing Visit PRN for administration.	Quantity: **(X1) Syringe**	Refills: _____
☐ **SANDOSTATIN** ☐ **octreotide acetate**	☐ 100 mcg/ mL ☐ 500 mcg/ mL	Administer 1 injection subcutaneously every 28 days. Skilled Nursing Visit PRN for administration.	Quantity: **(X1) Syringe**	Refills: _____
☐ **Other:** _____	_____	_____	Quantity: _____	Refills: _____

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
☒ EPINEPHRINE **(autoinjector)**	Administer IM for anaphylactic reaction. May repeat in 5-15 minutes severe ☐ ***0.3 mg (Wt > 30 kg)*** ☐ ***0.15 mg (Wt 15-30 kg)*** ☐ ***0.1 mg (Wt 7.5-15 kg)***	Quantity: **(x2) Pen(s)**	Refills: **PRN**

NURSING/ INFUSION SUPPLIES:

☒ **NURSING:** Nursing visits with each infusion to establish Subcutaneous administer medication, assess and monitor patient, and provide education.

☒ **INFUSION SUPPLIES:** Infusion supplies for the administration and disposal of medication.

5 PRESCRIBER INFORMATION

Prescriber Name: _____ **Title:** ☐ MD ☐ DO ☐ ND ☐ PA ☐ APRN **NPI:** _____
Address: _____ **City/ State/ Zip:** _____
Phone: _____ **Fax:** _____ **Contact Person:** _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record.
I authorize IV Solutions RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future refills of the same prescription for the patient listed above. I understand that I can revoke the designation at any time by providing written notice to IV Solutions RX.
CONFIDENTIALITY NOTICE: The information contained in this transmission may contain confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email to **info@ivsolutionsrx.com** and destroy all copies of the original message.

_____ **Prescribers Signature** _____ **Date**

THANK YOU FOR YOU TRUSTING US IN YOUR PATIENTS SPECIALTY CARE *#welcome to our family*

5315 Avion Park Drive, Suite 120 Tampa, Florida 33607