

Acromegaly Injection REFERRAL FORM



FAX REFERRAL TO: +1(844) 277-0049

PHONE: +1(844) 650-5802

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
<input type="checkbox"/> Lanreotide	<input type="checkbox"/> 60mg/0.2mL PFS <input type="checkbox"/> 90mg/0.3mL PFS <input type="checkbox"/> 120mg/0.5mL PFS	Administer 1 injection subcutaneously every 28 days. Skilled Nursing Visit PRN for administration.	Quantity: (X1) Syringe	Refills: _____
<input type="checkbox"/> SANDOSTATIN LAR DEP <input type="checkbox"/> octreotide acetate LAR	<input type="checkbox"/> 10 mg Vial <input type="checkbox"/> 20 mg Vial <input type="checkbox"/> 30 mg Vial	Administer 1 injection subcutaneously every 28 days. Skilled Nursing Visit PRN for administration.	Quantity: (X1) Syringe	Refills: _____
<input type="checkbox"/> SANDOSTATIN <input type="checkbox"/> octreotide acetate	<input type="checkbox"/> 100 mcg/ mL <input type="checkbox"/> 500 mcg/ mL	Administer 1 injection subcutaneously every 28 days. Skilled Nursing Visit PRN for administration.	Quantity: (X1) Syringe	Refills: _____
<input type="checkbox"/> Other: _____			Quantity: _____	Refills: _____

ANAPHYLAXIS PROTOCOL:

MEDICATION	DIRECTION	QUANTITY	REFILLS
<input checked="" type="checkbox"/> EPINEPHRINE (autoinjector)	Administer IM for anaphylactic reaction. May repeat in 5-15 minutes severe <input type="checkbox"/> 0.3 mg (Wt > 30 kg) <input type="checkbox"/> 0.15 mg (Wt 15-30 kg) <input type="checkbox"/> 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 SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

Prescriber Name: _____ Title: MD DO ND PA APRN NPI: _____

Address: _____ City/ State/ Zip: _____

Phone: _____ Fax: _____ Contact Person: _____

DISPENSE AS WRITTEN BRAND MEDICALLY NECESSARY DO NOT SUBSTITUTE May Substitute / Product Selection Permitted / Substitution Permissible
 NO SUBSTITUTION / DAW / MAY NOT SUBSTITUTE

PRESCRIBER'S SIGNATURE: _____ DATE: _____ Prescriber's Signature: _____ Date: _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution." NY & IA: electronic prescription required.

Prescribers are to comply with state-specific prescription regulations, which may include requirements for electronic prescribing, generic substitution, authorized prescription formats, and fax language. Noncompliance with these requirements may prompt follow-up communication with the prescriber.

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.