SANDOSTATIN LAR DEPOT INJECTION ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	□ inches □ cm	Weight:	□lbs. □ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:	Fax:	
Office Contact:			Email:	
Address:		City:	State:	ZIP:
NPI #:	DEA#:		Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
SandostatinLARDepot (octreotide acetate)	□ 20mg IM intragluteally every 4 weeks □ _____ mg IM intragluteally every 4 weeks □ Other: _____	□ x 3 doses □ _____

Other orders: _____

Lab orders: _____ Lab Frequency: _____

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. □ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:**

COMPREHENSIVE SUPPORT FOR SANDOSTATIN LAR DEPOT THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Please answer the following for acromegaly:

- Does the patient have a high pre-treatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range? □ Yes □ No
- Has the patient had an inadequate or partial response to surgery or radiotherapy? □Yes □ No If no, please explain _____

☐ Include labs and/or test results to support diagnosis

☐ Other medical necessity: _____