



A Carelon Company

SANDOSTATIN LAR DEPOT INJECTION ORDERS

P: 877-365-5566 | **F:** 855-889-2946

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> 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
Sandostatin LAR Depot (octreotide acetate)	<input type="checkbox"/> 20mg IM intragluteally every 4 weeks	<input type="checkbox"/> x 3 doses <input type="checkbox"/> _____
	<input type="checkbox"/> _____ mg IM intragluteally every 4 weeks	
	<input type="checkbox"/> Other: _____	

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 Paragon Healthcare, Inc. 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:



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COMPREHENSIVE SUPPORT FOR SANDOSTATIN LAR DEPOT THERAPY

PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL CROSSING & 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: _____