Acromegaly

PRESCRIPTION & ENROLLMENT FORM

❑ New Patient
❑ Current

1 PATIENT INFORMATION

Patient's Name ______________________
Date of Birth ____________ ❑ Male ❑ Female Last 4 digits of SSN__________
Street Address ______________________ Apt#__________
City ______________________ State ________ Zip __________
Parent/Guardian (if applicable) ______________________
Home Phone ______________________ Work Phone ______________________
Cell Phone ______________________ Evening Phone ______________________
E-mail address ______________________
Insurance Company Name ______________________
Insurance Company Phone No. ______________________
Insured's Name ______________________
Insured's Employer ______________________
Relationship to Patient ______________________
Identification No.______________________ Policy/Group No. ______________________
Prescription Card ❑ No ❑ Yes If Yes, Carrier ______________________
Policy No. ______________________ Group No. ______________________
Is patient eligible for Medicare? ❑ No ❑ Yes **Please attach front and back copy of patient's insurance cards, if available.**

2 PRESCRIBER INFORMATION

Prescriber's Name ______________________
Office Contact ______________________
Clinic / Hospital Affiliation ______________________
Street Address______________________Suite # __________
City ______________________ State ________ Zip __________
Phone ______________________ Fax ______________________
NPI No. ______________________ License No. ______________________
DEA No. ______________________
Physician Medicaid UPIN No. ______________________
MD Specialty ______________________

To reach your team, call toll-free **1 877 218-0410**.

Please fax completed form to the Acromegaly team
1 888 355-6682.

3 CLINICAL INFORMATION

PRIMARY DIAGNOSIS (CHECK ONE) ❑ Adult ❑ Pediatric
Diagnosis: ______________________

Weight (kg) ______________________ Height (cm) ______________________

Please attach information for Growth Disorder Diagnosis:

- **Current History/Physical and Clinic Notes**
- **Growth Charts/Velocity**
- **Bone Age**
- **GH Stimulation Test Results**
- **IGF-I Results**
- **Other Laboratory Results**

PRESCRIPTION

❑ **Somatuline® Depot (lanreotide) Injection**

STRENGTH
❑ 60 mg ❑ 90 mg ❑ 120 mg

ROUTE
Deep subcutaneous

FREQUENCY
❑ Every 28 days ❑ Other:__________

QUANTITY: __________ **# of refills:** __________
Special Instructions : ______________________
____

Somatuline® Depot History

Patient ❑ has ❑ has not received Somatuline® Depot previously
Date of last dose: __________ Dose received: __________mg
Date of next or first scheduled injection: ______________________

Note to TN prescribers - Quantity must be written in both numerals and words (ex. 3(three) doses)

SHIP DRUG TO: ❑ Physician's Office ❑ Patient's Home
(If shipped to physician's office, physician accepts on behalf of patient for administration in office.)
Injection Training ❑ **Yes** ❑ **No**
By: ❑ MD Office ❑ Alternate Agency ______________________
❑ Accredo ❑ Agency Phone ______________________

I certify that the prescribed GH is not for cosmetic, anti-aging or athletic enhancement purposes and is medically necessary and I will be supervising the patient's treatment accordingly.

Prescriber's Printed Name ______________________
Prescriber's Signature (sign below) **Date** __________

______________________ ______________________

Dispense as Written **Substitution Allowed**

(Physician attests this is his/her legal signature. **NO STAMPS**)

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GDT-00003-081908