



**Phone: 1-888-899-7447**  
**Fax: 1-866-368-9808**

**CAP**  
**Endocrinology**  
**Patient Order Form**

**PATIENT INFORMATION**

Patient Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Allergies	<input type="checkbox"/> NKDA
Date of Birth	SSN#	Weight _____	<input type="checkbox"/> kg <input type="checkbox"/> lb Date
Address	City	State	Zip
Phone # (Home)	(Work)	Email address(optional)	

**INSURANCE INFORMATION (PLEASE ATTACH A PHOTOCOPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS)**

Primary Insurance	Medicare ID
Group #	Policy #
Secondary Insurance	Phone #
Policy #	Phone #

**DIAGNOSIS/MEDICAL INFORMATION (PLEASE SPECIFY PRIMARY AND SECONDARY DIAGNOSES)**

If Prescribing <b>Sandostatin® LAR or octreotide:</b> <input type="checkbox"/> 253.0 Acromegaly <input type="checkbox"/> 259.2 Carcinoid Syndrome/Tumor <input type="checkbox"/> 259.2 VIPoma <input type="checkbox"/> Other ICD 9 _____	If Prescribing <b>Somatuline® Depot:</b> <input type="checkbox"/> 253.0 Acromegaly <input type="checkbox"/> Other ICD 9 _____	If prescribing <b>Thyrogen®:</b> <b>Diagnosis:</b> <input type="checkbox"/> 193 Malignant Neoplasm of Thyroid Gland <input type="checkbox"/> Other ICD 9 _____  <b>Procedure:</b> <input type="checkbox"/> Tg <input type="checkbox"/> Tg/Scan <input type="checkbox"/> Ablation
--	---	---

**PRESCRIPTION INFORMATION**

Medication	Dose	Directions/Frequency of Administration	Total # Doses
<input type="checkbox"/> octreotide acetate injection	Dose: _____	Directions: _____	<input type="checkbox"/> 1 dose <input type="checkbox"/> Other: _____
<input type="checkbox"/> Sandostatin® LAR (octreotide acetate injectable suspension)	<input type="checkbox"/> 10 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 30 mg	<input type="checkbox"/> Inject IM intragluteally once every 4 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 dose <input type="checkbox"/> Other: _____
<input type="checkbox"/> Somatuline® Depot (lanreotide injection)	<input type="checkbox"/> 60 mg <input type="checkbox"/> 90 mg <input type="checkbox"/> 120 mg	<input type="checkbox"/> Give via deep subcutaneous route every 4 weeks	<input type="checkbox"/> 1 dose <input type="checkbox"/> Other: _____
<input type="checkbox"/> Thyrogen®(thyrotropin alfa for injection)	<input type="checkbox"/> 0.9 mg	<input type="checkbox"/> Give IM every 24 hours for 2 doses <input type="checkbox"/> Other _____	<input type="checkbox"/> 2 doses <input type="checkbox"/> Other: _____

**DELIVERY INSTRUCTIONS**

<b>Order will be shipped to the address provided below. Physician must be registered with CAP at this location and this must be the site of administration.</b>	<b>Administration Date *</b>
---	------------------------------

**PHYSICIAN CONTACT INFORMATION & AUTHORIZATION**

Physician Name	Office Contact	Institution
Phone	Fax	Specialty
Address	City/State/Zip	
DEA #	UPIN #	
CAP PIN #	NPI #	

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (required to process prescription – stamped signatures are not permissible)

**\*If this order is needed in less than 48 hours please call 888-899-7447 to place order.**