

SANDOSTATIN LAR DEPOT (OCTREOTIDE ACETATE) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____ kg
 Allergies: _____
 Patient has known difficult venous access. Comments: _____

DIAGNOSIS (Provider must specify)

- Acromegaly, ICD 10: E22.0
- Severe diarrhea/flushing episodes associated with metastatic carcinoid tumors, ICD 10: E34.0
- Profuse watery diarrhea associated with Vasoactive Intestinal Peptide (VIP) secreting tumors, ICD 10: E16.8
- Other: _____

PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____
 Signature: _____ Date: _____
 Contact Name: _____ Phone: _____ Fax: _____
 Email Address: _____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

- Demographics Labs and tests supporting diagnosis Office/progress notes

PRE-MEDICATION (Not typically indicated)

- | | | |
|--|---|--|
| <input type="checkbox"/> Acetaminophen (Tylenol) 500 mg PO | <input type="checkbox"/> Famotidine 20 mg IV | <input type="checkbox"/> Methylprednisolone (Solu-Medrol) 125 mg IVP |
| <input type="checkbox"/> Benadryl 25mg PO | <input type="checkbox"/> Cetirizine (Zyrtec) 10 mg PO | |
| <input type="checkbox"/> Other: _____ Dose: _____ Route: _____ | | |

Order valid for 1 year from date of signature unless otherwise specified here: _____

FAX NUMBERS:

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> CT: 203.433.0621 | <input type="checkbox"/> MA: 413.296.8482 | <input type="checkbox"/> NC: 919.984.8698 | <input type="checkbox"/> NY: 631.250.6020 | <input type="checkbox"/> SC: 864.973.6279 |
| <input type="checkbox"/> FL: 904.877.9270 | <input type="checkbox"/> MD: 240.224.8607 | <input type="checkbox"/> NH: 603.217.5371 | <input type="checkbox"/> OH: 937.871.4594 | <input type="checkbox"/> VA: 703.202.0499 |
| | <input type="checkbox"/> ME: 207.407.7272 | <input type="checkbox"/> NJ: 201.581.4521 | <input type="checkbox"/> PA: 610.273.5998 | |

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MEDICATION

MEDICATION	DOSE / FREQUENCY	ROUTE
Sandostatin LAR Depot	<p><u>Patients Not Currently Receiving Sandostatin Injection Subcutaneously:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Acromegaly: 50 mcg three times daily Sandostatin Injection subcutaneously for 2 weeks followed by SANDOSTATIN LAR DEPOT 20 mg intragluteally every 4 weeks for 3 months <input type="checkbox"/> Carcinoid Tumors and VIPomas: Sandostatin Injection subcutaneously 100 to 600 mcg/day in 2-4 divided doses for 2 weeks followed by SANDOSTATIN LAR DEPOT 20 mg every 4 weeks for 2 months. <p><u>Patients Currently Receiving Sandostatin Injection Subcutaneously:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Acromegaly: 20 mg every 4 weeks for 3 months <input type="checkbox"/> Carcinoid Tumors and VIPomas: 20 mg every 4 weeks for 2 months. <input type="checkbox"/> Renal Impairment, Patients on Dialysis: 10 mg every 4 weeks <input type="checkbox"/> Hepatic Impairment, Patients With Cirrhosis: 10 mg every 4 weeks 	SC

New Start Therapy
 Continuation of Therapy
 Date of last dose (if applicable): _____

LABS / SPECIAL INSTRUCTIONS

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