WELLPARTNER PHARMACY | ACROMEGALY ENROLLMENT FORM

Wellpartner

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:

Address:

City, State, ZIP:

Primary Phone: - - DOB: / /

Alternate Phone: - - Gender:

Email:

Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:

DEA #: NPI #: State Lic. #:

Group or Hospital:

Address:

City, State, Zip:

Phone: - - Fax: - -

Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:

Primary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

Secondary Insurance Company Name:

Secondary Cardholder Name:

Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent

Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / / Last Visit: / / Next Visit: / /

◯ E22.Ø Acromegaly and pituitary gigantism

◯ Other:

Height (in/cm): Weight (lb/kg): IGF-1 levels: GH levels:

Has patient previously been on medication for acromegaly? ◯ Yes ◯ No

If yes, start date and product:

Allergies:

Does this patient have an active pituitary tumor or history of one? ◯ Active ◯ History ◯ No

If history, how long has the tumor been absent?

Current Medications:

Is the patient a candidate for radiation or surgery? ◯ Yes ◯ No

Has patient received injection training? ◯ Yes ◯ No

Has the patient had an inadequate response to radiation or surgery? ◯ Yes ◯ No

◯ Patient is interested in patient support programs.

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Sandostatin Injection® Ampules	◯ 50 mcg/ml ◯ 100 mcg/ml ◯ 500 mcg/ml	◯ Administer _____ mcg subcutaneously three times daily. ◯ Other:		
◯ Sandostatin Injection® MDV	◯ 200 mcg/ml (5 ml) ◯ 200 mcg/ml (5 ml)	◯ Administer _____ mcg subcutaneously three times daily. ◯ Other:		
◯ Sandostatin LAR® Depot	◯ 10 mg vial kit ◯ 20 mg vial kit ◯ 30 mg vial kit	◯ Administer _____ mcg subcutaneously three times daily. ◯ Other:	◯ 4-week supply ◯ 12-week supply ◯ Other:	
◯ Somatuline® Depot	◯ 60 mg prefilled syringes ◯ 90 mg prefilled syringes ◯ 120 mg prefilled syringes	◯ Inject 90 mg (1 syringe) SQ every 4 weeks. ◯ Other: Inject _____ mg (1 syringe) SQ every 4 weeks.	◯ 4-week supply ◯ 12-week supply ◯ Other:	
◯ Somavert® (LD)*	(LD)* This is a limited distribution drug that requires additional handling. Please call (1.800.473.3516) for more information.			
◯				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /

DISPENSE AS WRITTEN DATE

X / /

PRODUCT SUBSTITUTION PERMITTED DATE