Eculizumab (Somatuline)

Provider Order Form rev. 12/01/2021

AleraCare
www.aleracaremedicalgroup.com
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PATIENT INFORMATION

Patient Name: DOB:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

ICD-10 CODE

☐ E22.0 Acromegaly

☐ Gastroenteropancreatic neuroendocrine tumors (GEP-NETs)

☐ E34.0 Carcinoid syndrome

☐ Other: _____

MEDICATION ORDER

Dosing:

☐ 90mg every ☐ 3 weeks ☐ 4 weeks

☐ 120mg every ☐ 3 weeks ☐ 4 weeks

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ ANA (SLE) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months