Sandostatin LAR (ocreotide)

Provider Order Form rev. 2/2/2022

AleraCare
CALIFORNIA
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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

☐ Severe diarrhea/flushing episodes associated with metastatic carcinoid tumors

☐ Profuse watery diarrhea associated with Vasoactive Intestinal Peptide (VIP) secreting tumors

☐ Other: _____

MEDICATION ORDER

Sandostatin

_____ mg q _____ ☐ Days ☐ Weeks

IM x _____ doses

SPECIAL INSTRUCTIONS

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)

☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months
☐ Fasting Glucose within 90 days of order ☐ TSH