aleracare
advanced infusion centers™

FAX 833.329.4738

Sandostatin LAR Depot (octreotide acetate)

Provider Order Form rev. 5/5/2023

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable): _____

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No Does the patient need interpreter services: ◯ Yes ◯ No

Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

ICD-10 CODE

◯ E22.0 Acromegaly ◯ R19.7 Diarrhea, unspecified ◯ Other: _____

Medication Order

Sandostatin LAR Depot
(octreotide acetate)

Dose: ◯ 10mg IM ◯ 40mg IM ◯ 20mg IM ◯ Other: _____ ◯ 30mg IM

Frequency: ◯ every 4 weeks ◯ Other: _____

Duration: ◯ for 2 months ◯ for 3 months ◯ Other: _____

Documentation Required (Note: Send all labs, must include specific labs listed here)

◯ Labs ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

Provider Name **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order ◯