aleracare
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FAX 833.329.4738

Somatuline Depot (lanreotide)

Provider Order Form rev. 5/20/2022

Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

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

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change 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:

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

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

ICD-10 CODE

◯ E22.0 Acromegaly ◯ E34.0 Carcinoid Syndrome ◯ Other: _____

Medication Order

Somatuline Depot (lanreotide)

Dose: ◯ 60mg SC ◯ 90mg SC ◯ 120mg SC

Frequency: ◯ every 4 weeks ◯ every 6 weeks ◯ Other: _____

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 ◯