Sandostatin LAR Depot (octreotide acetate)

Provider Order Form rev. 5/20/2022

VASCO INFUSION
www.vascoinfusion.com
ph: 602-346-0204 fax: 877-637-6691

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 Code:

DOCUMENTATION (REQUIRED)

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

ICD-10 CODE

☐ E22.0 Acromegaly

☐ R19.7 Diarrhea, unspecified

☐ Other: _____

SPECIAL INSTRUCTIONS

MEDICATION ORDER

Sandostatin LAR Depot (octreotide acetate)

Dose:

☐ 10mg IM

☐ 20mg IM

☐ 30mg IM

☐ 40mg IM

☐ Other: _____

Frequency:

☐ every 4 weeks

☐ Other: _____

Duration

☐ for 2 months

☐ for 3 months

☐ Other:_____

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

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

☐ **Check here if this is a stat order**