ID Infusion Center
CONSULTANTS INC

SIGNIFOR LAR (pasireotide)

FAX TO (216) 378-9824

FOR QUESTIONS, CALL (216) 360-0456

1 PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____

Allergies: _____ Ht (in): _____ Wt (kg): _____ Gender: M | F

Demographic Information Attached: ◯ **Yes**

Insurance Information Attached (front and back of card): ◯ **Yes**

Infusion location: ◯ Beachwood ◯ Painesville ◯ Fairlawn ◯ Westlake ◯ Middleburg Heights ◯ Youngstown

Patient Status: ◯ New to Therapy
◯ Order Renewal
◯ Change of Dose | Frequency
◯ Continuing Treatment | Transfer from a Prior Site of Care. Next Treatment Due Date: _____
(Efforts will be taken to maintain treatment schedule, but next due date cannot be guaranteed)

2 CLINICAL INFORMATION

ICD-10 Code (required & as specific as possible): _____ ICD-10 Description: _____

Clinical/Progress Notes, Labs, Tests Supporting Primary Diagnosis Attached: ◯ Yes

Baseline ECG Results Attached: ◯ Yes

Supporting Lab Results Attached: ◯ Yes

3 INFUSION ORDER

Signifor LAR: ◯ 10 mg injected intramuscularly every 4 weeks
◯ 20 mg injected intramuscularly every 4 weeks
◯ 30 mg injected intramuscularly every 4 weeks
◯ 40 mg injected intramuscularly every 4 weeks
◯ 60 mg injected intramuscularly every 4 weeks

Comments/Special Considerations: _____

LAB REQUIREMENTS & LAB MONITORING ARE THE RESPONSIBILITY OF THE PRESCRIBER. INFUSION ORDERS ARE VALID FOR ONE YEAR (UNLESS OTHERWISE SPECIFIED). INFUSIONS WILL BE ADMINISTERED PER ID CONSULTANTS INFUSION CENTER POLICY AND PROTOCOLS.

4 PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

Practice Name: _____ Fax: _____

Office Contact: _____ Email: _____

Prescriber Signature: _____ Date: _____

FOR MORE INFORMATION OR TO ACCESS REFERRAL FORMS, VISIT OUR WEBSITE AT WWW.IDCONSULTANTS.COM/ORDER_FORMS