anovo SPECIALTY PHARMACY

Signifor® & Signifor® LAR (pasireotide) Patient Prescription Form

Fax: 855-813-2039
Phone:888-855-RARE (888-855-7273)

If your office has not received a confirmation fax that your referral has been received within 24 hours after submission, please refax or call AnovoRx at (888) 855-RARE (7273).

Please select one: ☐ **Newly Prescribed Patient** ☐ **Patient Currently on Signifor®LAR/Signifor®**

Patient Information
** Please Print*

Last Name: First Name:		SSN:	Sex: ◯M ◯F
Address:	City:	State:	Zip:
Phone: Day #	Evening #:	Cell # :	
DOB:		Email:	
If Patient is a Minor, Guardian/Parent Name:		Relation to Patient:	
Emergency Contact:		Phone #:	

Insurance Information
** Complete this section or include copy of insurance card*

Primary Insurance Co. Name:		Phone #:
Policy Holder Name:	Policy #:	Group #:
Prescription Card Name:		Phone #:
Policy #:		Group #:
Secondary Insurance Co. Name:		Phone #:
Policy Holder Name:	Policy #:	Group #:

Physician Information

Prescriber Name/Title:		
NPI: Medicaid UPIN:		State License #:
Address:		
City:	State: Zip:	
Name of Contact Person:		Phone:
Physician/Office Contact Email:		Fax:

Prescription

Signifor® (pasireotide) injection *for subcutaneous use*

☐ 0.3 mg ampules ☐ 0.6 mg ampules ☐ 0.9 mg ampules
(60 ampules per box)

☐ Inject the contents of one ampule subcutaneously twice daily
☐ Other: _____

☐ 1-month supply ☐ 3-month supply ☐ Other:_____

Refills _____

Signifor administration supplies include:
- 1 mL syringe
- 27G 1/2" needle
- 18G 1/2" filter needle
- Alcohol prep pads
- Band-Aid® bandages
- Sharps container

Signifor® LAR (pasireotide) for injectible suspension *for intramuscular use*

☐ 10 mg kit ☐ 20 mg kit ☐ 30 mg kit ☐ 40 mg kit ☐ 60 mg kit

☐ Healthcare provider to inject one syringe intramuscularly every 28 days
☐ Other: _____

☐ 1-month supply ☐ Other:_____

Refills _____

Signifor LAR administration supplies include:
- Alcohol swabs
- Sharps container

Note: Signifor LAR kit includes diluent, syringe, and injection needle supplied by manufacturer

Supplies: (supplies will be sent unless indicated below) Dispense needles, syringes, and ancillary supplies necessary to administer medication. Quantity to be supplied sufficient for prescribed days supply above.

☐ **No Supplies**

Clinical Background

Please check applicable ICD-10 code:

☐ Cushing's Disease, pituitary-dependent (E24.0)
☐ Cushing's Disease, unspecified (E24.9)
☐ Acromegaly (E22.0)
☐ Other (please specify)_____

☐ NKDA
☐ Drug Allergies _____
Concurrent Medications: _____
_____

Please attach baseline/most recent laboratory and biomarker values, prior dates of surgery, and past medication therapies used with referral.

Nursing

Does Signifor LAR patient require or prefer home administration?

☐ Yes: Skilled nursing visit as needed to administer medication and assess general status and response to therapy
☐ No: Patient to receive injection administration from Prescriber's office, designated clinic, or infusion provider
If shipped to physician's office, physician accepts on behalf of patient for administration in office.

I certify I am prescribing Signifor® LAR/Signifor® for this patient for a medically necessary purpose. **Date Written:**_____

Dispense as Written: _____
(Stamped Signatures Are Not Valid)

Substitution Allowed: _____
(Stamped Signatures Are Not Valid)

This patient referral form is only valid if FAXED directly from the prescriber to Anovo @ 855-813-2039

Form: Signifor.RX.187
Effective Date: 12.1.20
Revision Date: