ADDRESS: 12144 DAIRY ASHFORD RD. SUITE 100 SUGAR LAND, TX 77478

DELIVERIT
Infusion & Specialty

PHONE: (832) 939-8137
FAX: (832) 939-8128

ENDOCRINOLOGY REFERRAL FORM

☐ **Infused at MDO.**

☐ **Infused at Home.** SET UP OF SKILLED NURSING VISITS REQUIRED.

COMPLETE PATIENT DEMOGRAPHIC INFORMATION IN SECTION BELOW

Or Attach Face Sheet from Patient Chart

Patient Name:		DOB:	Gender: ☐ Male ☐ Female	Weight:	☐ lbs ☐ kg
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip code :	

COMPLETE PATIENT INSURANCE INFORMATION IN THE SECTION BELOW

Or Attach Copies of Patient's Insurance Card

Primary insurance Carrier:	Name of the Insured:	Relationship:
Member ID #:	Group #:	Insurance Phone #:
Secondary Rx Carrier Name:	Rx ID #:	Rx Group #:

ICD-10 Code ☐ _____	Secondary ICD-10 Code ☐ _____	Date of diagnosis _____
Is Patient new to therapy? ☐ Yes ☐ No	Diagnosis _____	

PRESCRIPTION

☐ **GENOTROPIN** Dose/Frequency/Route _____

SIG: _____ QTY: _____ Refill: _____

☐ **HUMATROPE** Dose/Frequency/Route _____

SIG: _____ QTY: _____ Refill: _____

☐ **NORDITROPIN** Dose/Frequency/Route _____

SIG: _____ QTY: _____ Refill: _____

☐ **OMNITROPE** Dose/Frequency/Route _____

SIG: _____ QTY: _____ Refill: _____

☐ **SAIZEN** Dose/Frequency/Route _____

SIG: _____ QTY: _____ Refill: _____

☐ **TEV-TROPIN** Dose/Frequency/Route _____

SIG: _____ QTY: _____ Refill: _____

☐ **FORTEO®** (#1 pen) SIG: Inject 20mg SQ Daily QTY: 1 pen with 30 needles Refills: _____

☐ **SAXENDA®** Multi-dose Pen ☐ 0.6 mg ☐ 1.2 mg ☐ 1.8 mg ☐ 2.4 mg ☐ 3 mg

SIG: Administer _____ mg daily QTY: _____ Refill: _____

☐ **REPATHA®** (evolocumab) **140 mg/ml single-use prefilled SureClick® autoinjector**

SIG: Inject 140 mg subcutaneously every 2 weeks QTY: ☐ 1 month ☐ 3 month ☐ Other: _____ Refill: _____

PRESCRIPTION CONT.

☐ **THYROGEN®** (thyrotropin alfa for injection) Dose/Frequency/Route _____

SIG: _____ QTY: _____ Refill: _____

☐ **CORTROSYN®** (cosyntropin for injection) Dose/Frequency/Route _____

SIG: _____ QTY: _____ Refill: _____

☐ **OTHER** SIG: _____ QTY: _____ Refill: _____

LIST ANCILLARY SUPPLIES IF NEEDED _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

COMPLETE PRESCRIBER INFORMATION IN SECTION BELOW

Prescriber Name:	NPI#:	Office#:	Fax#:
Address:	City:	State:	Zipcode:

SIGNATURE OF LICENSED PRESCRIBER (REQUIRED TO VALIDATE PRESCRIPTION)

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

Prescriber's Signature:

X_____

☐ DAW(Dispense as Written) Date: _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.