

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

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

Patient Information <small>* Please Print</small>	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 <small>* Complete this section or include copy of insurance card</small>	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	<b>Signifor® (pasireotide) injection</b> <i>for subcutaneous use</i>  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: <ul style="list-style-type: none"> <li>• 1 mL syringe</li> <li>• 27G 1/2" needle</li> <li>• 18G 1/2" filter needle</li> <li>• Alcohol prep pads</li> <li>• Band-Aid® bandages</li> <li>• Sharps container</li> </ul> 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.  <b>No Supplies</b>				<b>Signifor® LAR (pasireotide) for injectible suspension</b> <i>for intramuscular use</i>  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: <ul style="list-style-type: none"> <li>• Alcohol swabs</li> <li>• Sharps container</li> </ul> <i>Note: Signifor LAR kit includes diluent, syringe, and injection needle supplied by manufacturer</i>			
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Clinical Background	Please check applicable ICD-10 code:							
	Cushing's Disease, pituitary-dependent (E24.0)				NKDA			
	Cushing's Syndrome, unspecified (E24.9)				Drug Allergies _____			
Acromegaly (E22.0)				Concurrent Medications: _____				
Other (please specify) _____				_____				
<b>Please attach baseline/most recent laboratory and biomarker values, prior dates of surgery, and past medication therapies used with referral.</b>								

Nursing	<b>Does Signifor LAR patient require or prefer home administration?</b>							
	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)