McLeod Health

Place Sticker Here

Octreotide (Sandostatin LAR) Treatment Plan

Patient Name: ____ DOB: _________________________

Height (cm): ______________________ Weight (kg): _________________ Allergies: ____________________

Diagnosis (select one):

☐ E22.0 Acromegaly and pituitary gigantism

☐ R19.7 Diarrhea, unspecified

☐ E34.0 Carcinoid syndrome

☐ C7A.8 Other malignant neuroendocrine tumors

☐ C7A.00 Malignant carcinoid tumor of unspecified site

☐ Other: ICD 10 Code: __________________ Diagnosis Description: __________________________________

Drug Orders:

- Octreotide (Sandostatin LAR) (J2353) via intramuscular injection
- Dose: ☐ 20 mg ☐ 30 mg ☐ Other: ______________
- Frequency: ☐ Every 4 weeks ☐ Other: _____________________
- Order Duration: Six months unless otherwise specified (Other: _____________________________________)
- Other: ____

Physician Signature: ____ **Date:** ____________________________

Physician Name: ____ **Phone:** ___________________________

Previous Therapies:

• For new patient referrals, please send history and physical and most recent physician note with completed plan

• If patient has previously received octreotide at another facility, please provide last date received: ____________

• If patient has previously received another somatostatin analog, please provide the name: _________________

and the last date received: ________________

Insurance/Authorization Information:

Insurance Type: ____

Insurance Authorization Reference Number: ____

Date Obtained: ____________________________ Authorization Valid Until: _________________________

Additional Notes: ____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Seacoast: 843-366-2224 (Fax)

843-366-3626 (Phone)