Alkindi Sprinkle® (hydrocortisone) oral granules

Patient Referral Form

Fax: 855-813-2039 Phone: 833-343-2500

anovo SPECIALTY PHARMACY

Please select one: ☐ **Newly Prescribed Patient** ☐ **Patient Currently on Alkindi Sprinkle®**

Patient Information *Please print

Last Name: First Name:		SSN:	Sex: ◯M ◯F
Address:	City:	State:	Zip:
Phone: Day #	Evening #:	Cell # :	Preferred method of Contact: ◯ Day # ◯ Evening # ◯ Cell #
DOB:	Weight Lbs:	Kg: Height:	BSA:
If Patient is a Minor, Guardian/Parent Name:		Relation to Patient:	
Emergency Contact:		Phone #:	

Insurance Information

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:			Phone #:
NPI:	DEA:	Medicaid UPIN:	State License #:
Address:	City:		State: Zip:
Name of Office Contact Person:		Office Contact Person Email:	
Office Contact Person Phone:		Office Contact Person Fax:	
PA Office Contact Name:		PA Office Contact Name:	

Prescription

Alkindi Sprinkle® (Hydrocortisone) capsules

Select all strengths needed for patient dosing:

☐ 0.5 mg capsule ☐ 2 mg capsule

☐ 1 mg capsule ☐ 5 mg capsule

Special Instructions:

_____

_____

_____

SIG: Take ____ mg daily in divided dose.

Dose 1 _____ mg Time: _____

Dose 2 _____ mg Time: _____

Dose 3 _____ mg Time: _____

Dose 4 _____ mg Time: _____

Dispense additional _____ mgs for sick day doses for _____ days per month.

** Sick day dose is normally 2 to 3 times normal dose depending on the severity of the event

Dispense:

☐ 30 day supply Refills _____

☐ Check here for no sick day dose requested

Medical Necessity

Primary diagnosis:	Date of Diagnosis :	Patient Age at Diagnosis:

Please check applicable ICD-10 code: Therapy Start Date: _____

☐ Congenital Adrenal Hyperplasia (E25.0)

☐ Congenital Adrenal Hyperplasia due to 21-Hydroxylase (E25.9)

☐ X-linked Adrenoleukodystrophy, unspecified (E71.529)

☐ Other _____

☐ Primary Adrenal Insufficiency (E27.1)

☐ Unspecified Adrenocortical Insufficiency (E27.40)

☐ Other Adrenocortical Insufficiency (E27.49)

☐ Disorders of the Adrenal Gland, unspecified (E27.9)

Allergies: _____ ☐ NKDA

I certify I am prescribing Alkindi Sprinkle® 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 Prescription Form is only valid if FAXED to Anovo @855-813-2039

Form: Alkindi.RX.01
Effective Date: 5.1.20
Revision Date: 9.4.20, 2.5.21, 9.11.22, 3.31.23
1210-v3