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:

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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
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