Khindivi™ (hydrocortisone) 1 mg/mL oral solution

Patient Referral Form

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

anovo

Please select one: ☐ **Newly prescribed patient** ☐ **Already on Khindivi™**

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:		Relationship 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

Khindivi™ (hydrocortisone) oral solution

☐ **1 mg/mL solution**

Dispense:
☐ **30 day supply**

Refills: _____

SIG: Take _____ mg daily in divided dose.

Dose 1 _____ mg Time: _____
Dose 2 _____ mg Time: _____
Dose 3 _____ mg Time: _____
Dose 4 _____ mg Time: _____

Stress Dosing Prescription (Optional)

OPTIONAL - Sick day (stress) dosing prescription **- Alkindi Sprinkle® (hydrocortisone) capsules**

☐ I'd like to prescribe Alkindi Sprinkle for stress dosing.

☐ **0.5 mg capsule** ☐ **2 mg capsule**
☐ **1 mg capsule** ☐ **5 mg capsule**

SIG: Dispense _____ 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.

Medical Necessity

Please check applicable ICD-10 code:

Therapy Start Date: _____

☐ **Congenital Adrenal Hyperplasia (E25.0)**
☐ **Primary Adrenal Insufficiency (E27.1)**
☐ **Other**
☐ **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 Khindivi™ 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:
Effective Date: 3/3/25
1927-v1