VERBAL ORDER FORM
ENDOCRINOLOGY

PFSP
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☐ Phone Order
Ship to Patient: ☐ Home ☐ Work
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☐ Nurse / Training
☐ PFSP Pharmacy

398 W. Grand Avenue | Rahway, NJ 07065
Ph 844-527-9486 | Fx 866-285-7628
NPI# 1669881777 NABP# 3148839
info@pfsprx.com PFSPrx.com

Today's Date _____
Date Needed _____

ACHC ACCREDITED
urac ACCREDITED Specialty Pharmacy Expires 07/01/2023
urac ACCREDITED Rare Disease Pharmacy Center of Excellence Expires 07/01/2023

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____

Primary Insurance_____ ID#_____ Group #_____
Insured's Name_____ Employer_____
City_____ State_____ Phone_____

ICD-10 Diagnosis Code: ☐ E78.5 Unspecified Hyperlipidemia ☐ E78.0 Pure Hypercholesterolemia ☐ E08.9 Diabetes Mellitus without complications
☐ E08.8 Diabetes Mellitus w/ unspecified complications ☐ M81.0 Age-related Osteoporosis ☐ E29.1 Testicular Hypofunction ☐ _____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____
Patient currently on therapy? ☐ Yes ☐ No Type/medication(s) _____
Current medications patient (including OTC) with dosage and direction (or fax medication) _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **TYMLOS™ 1.56mL Prefilled Multi-Dose Pen**
SIG: Inject 80mcg SQ once a day QTY: 1 Pen (30 day supply) Refill: _____

☐ **FORTEO® 600mcg/2.4mL** SIG: Inject 20mcg SQ daily as directed
QTY: ☐ 1 Pen (4 week supply) ☐ 3 Pens (12 week supply) Refill: _____

☐ **PROLIA® 60mg PFS** SIG: Inject 60mg SQ every 6 months QTY: 1 Refill: _____

☐ **RECLAST® 5mg/100mL Vial** SIG: 5mg IV once yearly QTY: 1 Refill: _____

☐ **EVENITY® 105mg/1.17mL PFS (2-count)**
SIG: Inject 210mg (2-105mg PFS) under the skin once monthly for 12 months
QTY: ☐ 2 PFS (1 month) ☐ 6 PFS (3 months) Refill: _____

ZORBTIVE™ ☐ **8.8mg lyophilized powder in single use vial for reconstitution**
☐ 0.1mg/kg SQ once daily to a maximum daily dose of 8mg for 4 weeks
QTY: _____ Refill: _____

☐ **XULTOPHY® 100/3.6** 100 units/mL insulin degludec and 3.6mg/mL liraglutide
SIG: Inject ____units SQ once daily QTY: 1 Pen (300 units) Refill: _____

☐ **EGRIFTA™ 1mg vial** SIG: Inject 2mg SQ once a day QTY: _____ Refill: _____

☐ **THYROGEN® (THYROTROPIN ALFA FOR INJECTION)**
SIG: _____ QTY: _____ Refill: _____

☐ **CORTROSYN® (COSYNTROPIN FOR INJECTION)**
DOSE/FREQUENCY/ROUTE: _____
SIG: _____ QTY: _____ Refill: _____

HUMAN GROWTH HORMONES
☐ **GENOTROPIN MINIQUICK®** ☐ 0.2mg ☐ 0.4mg
☐ **HUMATROPE® CARTRIDGE KIT** ☐ 6mg ☐ 12mg
☐ **NORDITROPIN® FLEXPRO®** ☐ 5mg ☐ 10mg
☐ **SAIZEN®** ☐ 5mg vial ☐ 8.8mg vial ☐ 8.8mg CLICK EASY
SIG: _____ QTY: _____ Refill: _____

ADVOCATE ULTRA-FINE PEN NEEDLES ☐ Short 8mm 31G ☐ Mini 5mm 31G
SIG: _____ QTY: 1 Box Refill: _____

PLEASE LIST ANCILLARY SUPPLIES IF NEEDED: _____
_____

☐ **ACTHREL® 100mcg**
SIG: _____ QTY: _____ Refill: _____

SAMSCA® ☐ **15mg** ☐ **30mg**
SIG: Take _____ mg once daily QTY: _____ Refill: _____

KUVAN ☐ **100mg tablets** ☐ **100mg powder** ☐ **500mg powder**
Patient Weight: _____(kg)
☐ 1 month to 6 years (10mg/kg dose): Take _____mg by mouth once daily
QTY: QS to 30 days supply Refill: _____
☐ 7 years and older (10 to 20mg/kg dose): Take _____mg by mouth once daily
QTY: QS to 30 days supply Refill: _____

LEUPROLIDE THERAPIES
☐ Lupaneta Pack 1-month (3.75 mg/5mg) ☐ Lupron Depot (3.75mg)
☐ Lupaneta Pack 3-month (11.25 mg/5mg) ☐ Lupron Depot (11.25mg)
SIG: _____ QTY: _____ Refill: _____

☐ **SANDOSTATIN® LAR DEPOT** ☐ **OCTREOTIDE**
☐ 10 mg/6mL ☐ 20 mg/6mL ☐ 30 mg/6mL
SIG: _____ QTY: 3 vials Refill: _____

SOMATULINE® DEPOT
☐ 60 mg/0.2mL PFS ☐ 90 mg/0.3mL PFS ☐ 120 mg/0.5mL PFS
SIG: _____ QTY: _____ Refill: _____

SENSIPAR® ☐ **30mg** ☐ **60mg** ☐ **90mg**
SIG: ☐ Take _____mg once daily with food QTY: _____ Refill: _____
☐ Take _____mg twice daily with food QTY: _____ Refill: _____
☐ Other: _____ QTY: _____ Refill: _____

☐ **SYNAREL® 8mL** QTY: 60 doses Refill: _____
SIG: ☐ Spray 1 spray in each nostril, morning and night
☐ Spray 2 sprays in each nostril, morning and night
☐ Spray 3 sprays in each nostril, morning and night
☐ Other: _____

OTHER MEDICATION_____
SIG:_____ **QTY:**____ **REFILL:**____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____
Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

Please fax completed referral form to **PFSP** at **866-285-7628**
Visit us at **PFSPrx.com** for online fillable forms.
Scan our QR Code to send us feedback about your experience.