Orsini Specialty Pharmacy

Fax: 877.218.6288 **Phone:** 888.204.7730

MIFEPRISTONE PATIENT ENROLLMENT

1 PATIENT INFORMATION

(Please complete the following information)

☒ **Please attach demographic information**

Patient Name (First, MI, Last): ______ DOB: ______ Gender: ◯ Male ◯ Female

Address: ______ City: ______ State: ______ Zip: ______

Patient Phone Number: ______

Parent/Caregiver Name (First, MI, Last): ______ Parent/Caregiver Phone Number: ______

2 INSURANCE INFORMATION

☒ **Please attach front and back of patient's insurance card, prescription card, and/or Medicaid card.**

Primary Insurance Name: ______

Primary Insurance ID: ______

Insurance Phone Number: ______

Policyholder Name: ______

Secondary Insurance Name: ______

Primary Insurance ID: ______

Insurance Phone Number: ______

Policyholder Name: ______

3 CLINICAL INFORMATION

☒ **Please fax clinical documentation to pharmacy along with referral form.**

☒ Lab test results, imaging results and chart notes confirming diagnosis of Cushing syndrome and presence of type 2 diabetes or glucose intolerance

☒ Prior surgical notes/consultations ☒ Negative pregnancy test for women of reproductive potential ☒ List of current medications being taken

Primary ICD-10 Diagnosis: ☐ Pituitary-dependent Cushing's disease ☐ E24.3 Ectopic ACTH syndrome ☐ E24.8 Other Cushing's syndrome ☐ E24.9 Cushing's syndrome, unspecified ☐ C74.0 Malignant neoplasm of cortex of adrenal gland ☐ Other ICD-10: ______

Secondary ICD-10 Diagnosis: ______ Allergies: ◯ NKDA ◯ Drug Allergies: ______

4 PRESCRIBER INFORMATION

Practice Name: ______

Prescriber Name: ______ Specialty: ______ NPI: ______

Address: ______ City: ______ State: ______ Zip: ______

Office Contact: ______ Phone: ______ Fax: ______

5 PRESCRIPTION INFORMATION

Mifepristone 300mg tablets (Recommended Initial Dose: 300mg orally once daily. Based on clinical response and tolerability, the dose may be increased in 300mg increments to a maximum of 1200mg once daily. Do not exceed 20mg/kg/day.)

INITIAL TITRATION DOSING

◯ Take 1 (one) tablet (300mg) by mouth daily for 14 days, then increase to 2 (two) tablets (600mg) daily Qty: 46 Refills: None Days Supply: 30

OTHER DOSING OPTIONS

◯ Take 1 (one) tablet (300mg) by mouth daily. Qty: 30 **Refills:** ______ Days Supply: 30

◯ Take 2 (two) tablets (600mg) by mouth daily. Qty: 60 **Refills:** ______ Days Supply: 30

◯ Take 3 (three) tablets (900mg) by mouth daily. Qty: 90 **Refills:** ______ Days Supply: 30

◯ Take 4 (four) tablets (1200mg) by mouth daily. Qty: 120 **Refills:** ______ Days Supply: 30

CUSTOMIZED DOSING

◯ ______ Qty: ______ **Refills:** ______ Days Supply: 30

______ ______

Physician's Signature Date of Signature

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by the express authority of the sender to the named addressee.

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