RARE SPECIALTY PHARMACY
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P: (855) 713-7049 | F: (888) 509-1154
398 W Grand Ave | Rahway, NJ 07065

Today's Date: _____
Date Needed: _____

Patient Name: _____ Date of Birth: _____/_____/_____ Gender: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Allergies/Notes: _____

(PLEASE ATTACH CLINICAL NOTES/LABS AND COPIES OF PATIENT'S INSURANCE CARDS)

Primary Insurance: _____ ID#: _____ Group#: _____ Insured's Name: _____
Employer: _____ City: _____ State: _____ Phone: _____

IDC-10 Diagnosis Code: ❑E78.5 Unspecified Hyperlipidemia ❑E78.0 Pure Hypercholesterolemia ❑E08.9 Diabetes Mellitus without complications
❑E08.8 Diabetes Mellitus with unspecified complications ❑M81.0 Age-related Osteoporosis ❑E29.1 Testicular Hypofunction ❑Other: _____
Type: ❑Relapsing-remitting ❑Primary Progressive ❑Secondary Progressive ❑Progressing Relapsing ❑Other Diagnosis: _____
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)_____

ENDOCRINOLOGY ORDER FORM

❑TYMLOS ❑1.56mL Prefilled Multi-Dose Pen — QTY: 1 Pen (30 day supply)
SIG: Inject 80mcg SQ once a day — Refills: _____

❑FORTEO ❑600mcg/2.4mL — QTY: ❑1 Pen (4 week supply) ❑3 Pens (12 week supply)
SIG: Inject 20mcg SQ daily as directed — Refills: _____

❑ADVOCATE ULTRA-FINE PEN NEEDLES — QTY: 1 Box
❑Short 8mm 31G ❑Mini 5mm 31G — Refills: _____
SIG:

❑PROLIA ❑60mg PFS — QTY: 1 PFS
SIG: Inject 60mg SQ every 6 months — Refills: _____

❑RECLAST ❑5mg/100mL Vial — QTY: 1 vial
SIG: 5mg IV once yearly — Refills: _____

❑EVENITY ❑105mg/1.17mL PFS 2-ct pack — QTY: ❑2 PFS (1 month)
SIG: Inject 210mg (2-105mg PFS) under the skin — QTY: ❑6 PFS (3 months)
once monthly — Refills: _____

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

❑XULTOPHY ❑100/3.6 100 units/mL insulin degludec and 3.6mg/mL liraglutide — QTY: 1 Pen (300 units)
SIG: Inject _____units SQ once daily — Refills: _____

❑EGRIFTA ❑1mg vial — QTY: _____
SIG: Inject 2mg subcutaneously once a day — Refills: _____

❑SKYTROPHA — QTY: _____
❑3mg ❑3.6mg ❑4.3mg ❑5.2mg ❑6.3mg — Refills: _____
❑7.6mg ❑9.1mg ❑11mg ❑13.3mg — Weight: _____ kg
SIG: Inject _____mg SubQ once weekly

❑YORVIPATH: Albumin corrected Serum Calcium level: _____
❑Starter:
Inject 18mcg SQ once daily with _____mg Calcium and _____mcg Calcitriol
❑Maintenance:
Inject _____mcg SQ once daily with _____mg Calcium and ____mcg Calcitriol

This prescription will be filled generically unless the prescriber writes "DAW" here: _____

HUMAN GROWTH HORMONES — QTY: _____
❑GENOTROPIN MINIQUICK ❑0.2mg ❑0.4mg — Refills: _____
❑HUMATROPE CARTRIDGE KIT ❑6mg ❑12mg
❑NORDITROPIN FLEXPRO ❑5mg ❑10mg
SIG:

❑SAMSCA ❑15mg ❑30mg — QTY: _____
SIG: Take 1 tablet once daily — Refills: _____

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

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

❑SANDOSTATIN LAR DEPOT ❑OCTREOTIDE
❑10 mg/6mL ❑20 mg/6mL ❑30 mg/6mL — QTY: 3 vials
SIG: — Refills: _____

❑SOMATULINE DEPOT — QTY: _____
❑ 60 mg/0.2mL PFS ❑ 90 mg/0.3mL PFS
❑ 120 mg/0.5mL PFS — Refills: _____
SIG:

❑SENSIPAR ❑30mg ❑60mg ❑90mg — QTY: _____
❑ SIG: Take 1 tablet once daily with food — Refills: _____
❑ SIG: Take 1 tablet twice daily with food
❑ SIG:

❑SYNAREL ❑8mL — QTY: 60 doses
❑ SIG: Spray 1 spray in each nostril, morning and night — Refills: _____
❑ SIG: Spray 2 sprays in each nostril, morning and night
❑ SIG: Spray 3 sprays in each nostril, morning and night
❑ SIG:

OTHER: _____ SIG: _____ QTY: ____ Refills: _____

Please list ancillary supplies if needed: _____

Prescriber Name/Practice: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Office Contact: _____
License#: _____ NPI#: _____ UPIN#: _____ DEA#: _____
Prescriber's Signature (signature required, no stamps): _____ Date: _____