anovo
SPECIALTY PHARMACY

# Alkindi Sprinkle®
# (Hydrocortisone)
# Patient Referral Form

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

**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: | | |
| NPI: DEA: Medicaid UPIN: | | State License #: |
| Address: | | |
| City: | State: Zip: | |
| Name of Contact Person: | | Phone: |
| Physician Email: | | Fax: |

## 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:**

_____
_____
_____

**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 _____

## 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.02
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