ADVANCED PHARMACY & RESPIRATORY CARE SOLUTIONS

Today's Date _____

ENDOCRINOLOGY REFERRAL FORM

Date Needed _____

26611 Cabot Road Suite B | Laguna Hills CA 92653
Ph 949-348-7900 | Toll Free 800-464-7736 | Fax 949-348-7920
NPI# 1922103142 NABP# 0547185
info@aps-rx.net APS-rx.net

☐ Phone Order
Ship to Patient:
☐ Home ☐ Work
Ship to:
☐ Physician Office
☐ Nurse / Training
☐ APS Pharmacy

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 with 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™ ☐ 1.56 mL Prefilled Multi-Dose Pen
SIG: Inject 80mcg subcutaneously once a day QTY: 1 Pen (30 day supply) REFILLS: _____

XULTOPHY® 100/3.6
☐ 100 units/mL insulin degludec and 3.6mg/mL liraglutide
SIG: Inject _____units subcutaneously once daily
QTY: 1 Pen (300 units) REFILLS: _____

FORTEO® ☐ 600MCG/2.4mL **SIG: Inject 20 MCG SQ Daily as Directed**
QTY: ☐ 1 Pen (4 week supply) ☐ 3 Pens (12 week supply) **REFILLS:** _____

PROLIA® ☐ 60MG PFS **SIG: Inject 60mg subcutaneously every 6 months**
QTY: ☐ 1 Pen (4 week supply) ☐ 3 Pens (12 week supply) **REFILLS:** _____

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

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

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

☐ **ANDRODERM®** ☐ 2MG PATCH ☐ 4MG PATCH
☐ **ANDROGEL® 1%** ☐ 25MG/2.5G PACKET ☐ 5MG/5G PACKET
☐ **ANDROGEL® 1.62%**
☐ 20.25MG/1.25G PACKET ☐ 40.5MG/2.5G PACKET ☐ 20.25MG/ACTUATION PUMP
☐ **AXIRON®:** 30MG/1.5mL ACTUATION
☐ **FORTESTA® 2%:** 10MG/ACTUATION PUMP
☐ **TESTIM® 1%:** 50MG/5G
☐ **TESTOSTERONE CYPIONATE:** ☐ 100MG/mL ☐ 200MG/mL
☐ **TESTOSTERONE ENANTHATE:** 200MG/mL
SIG: _____ **QTY:**_____ **REFILLS:** _____

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:**_____ **REFILLS:** _____

LONG ACTING INSULIN
☐ **LANTUS® SOLOSTAR®:** 100 UNITS/mL
☐ **TOUJEO® SOLOSTAR®:** 300 UNITS/mL
☐ **LEVEMIR® FLEXTOUCH®:**100 UNITS/mL
☐ **TRESIBA® FLEXTOUCH®** ☐ 100 UNITS/mL ☐ 200 UNITS/mL
SIG: _____ **QTY:**_____ **REFILLS:** _____

RAPID-ACTING INSULIN
☐ **HUMALOG® KWIKPEN** ☐ 100 UNITS/mL ☐ 200 UNITS/mL
☐ **NOVOLOG® FLEXPEN®:**100 UNITS/mL
☐ **APIDRA® SOLOSTAR®:** 100 UNITS/mL
SIG: _____ **QTY:**_____ **REFILLS:** _____

GLP-1 AGONIST
☐ **VICTOZA® PEN** ☐ 1.2MG 2 PACK ☐ 1.8MG 3 PACK
☐ **BYDUREON® PEN:**2MG
☐ **BYETTA® PEN** ☐ 5MCG ☐ 10MCG
☐ **TRULICITY® PEN** ☐ 0.75MG ☐ 1.5MG
☐ **TANZEUM® PEN** ☐ 30MG ☐ 50MG
SIG: _____ **QTY:**_____ **REFILLS:** _____

BD ULTRA-FINE PEN NEEDLES
☐ Short 8mm 31G ☐ Mini 5mm 31G
SIG: _____ **QTY:**1 Box **REFILLS:** _____

WEIGHT MANAGEMENT
☐ **SAXENDA®:** 18MG/3mL
☐ **BELVIQ®:** 10MG
☐ **CONTRAVE®:** 8/90MG
☐ **QSYMIA®:** ☐ 3.75/23MG ☐ 7.5/46MG ☐ 11.25/69MG ☐ 15/92MG
SIG: _____ **QTY:**_____ **REFILLS:** _____

PLEASE LIST ANCILLARY SUPPLIES IF NEEDED
_____

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
APS at **949-348-7920**
Visit us at **APS-rx.net** for online fillable forms.