Becky,
MYCAPSSA
patient

Mycapssa®
(octreotide) capsules 20mg

Getting Started Guide

To get a patient started on MYCAPSSA®
follow 2 steps outlined in this guide

Visit chiesitotalcare.com
or call 1-833-346-2277
We're ready to help!

INDICATION AND IMPORTANT SAFETY INFORMATION

INDICATION AND USAGE

MYCAPSSA (octreotide) delayed-release capsules, for oral use, is a somatostatin analog indicated for long-term maintenance treatment in acromegaly patients who have responded to and tolerated treatment with octreotide or lanreotide.

CONTRAINDICATIONS

Hypersensitivity to octreotide or any of the components of MYCAPSSA. Anaphylactoid reactions, including anaphylactic shock, have been reported in patients receiving octreotide.

Please see additional Important Safety Information throughout and accompanying full Prescribing Information.

Chiesi TOTAL care℠

Step 1: Fill out the Prescription and Patient Consent Forms

Chiesi TOTAL care℠

Prescription Form

To Be Completed by Prescriber

Mycapssa® (octreotide) capsules 20mg

1. First prescription for the patient: Fax completed form to 1-833-746-2277
2. Subsequent prescription: May be e-script via AcariaHealth Specialty Pharmacy in your EMR/HMR system Call 1-833-346-2277 if you have questions regarding this form or contact Chiesi Total Care℠

1. PATIENT INFORMATION (all fields in this section are mandatory)

Patient Name (First, Middle, Last) _____ Email _____
Last 4 of Social Security # _____ Gender at birth ☐ Male ☐ Female Date of Birth_____ (mm/dd/yyyy)
Address _____ City _____ State _____ Zip _____
Mobile # _____ Alternative Phone # _____ Language: ☐ English ☐ Other _____

Caregiver Name _____ ☐ OK to leave message
Email _____ Caregiver Phone # _____
Allergies _____ Current Medications: _____
☐ No known drug allergies (NKDA)

2: INSURANCE INFORMATION (check the relevant box and complete as much as possible)

Please attach copies of both sides of the patient's insurance card.

☐ Medicare ☐ Medicaid ☐ Commercial/Private ☐ Other ☐ Uninsured
Primary Insurance Payer _____ Plan Name _____
Phone # _____ Policy ID # _____
Group # _____ BIN _____
PCN _____ Policy Holder's Name: _____
Policy Holder's Date of Birth _____ Policy Holder's Relationship to Patient _____

3: PRESCRIBER INFORMATION* (all fields in this section are mandatory)

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Name (First, Middle, Last) _____ Prescriber NPI # _____
Prescriber Tax ID #: _____ Facility Name _____
Facility Address _____ City _____ State _____ Zip _____
Facility Phone # _____ Preferred Fax # _____

Primary Contact Name _____ Title/Role _____
Primary Contact Phone # _____ Primary Contact Email _____

4: TREATMENT AND PRESCRIBING INFORMATION (mandatory)

Rx Treatment: MYCAPSSA® (octreotide) delayed-release oral capsules NDC: 69880-120-28. Dispense as written.
Please check a box below for medication strength* (mandatory)

Patient, at any time, has been prescribed octreotide or lanreotide
☐ yes
☐ no

A

☐ **ICD-10/Diagnosis: E22.0 (acromegaly and pituitary gigantism)**
☐ ICD-10/Diagnosis: D35.2 (benign neoplasm of the pituitary gland)
☐ ICD-10/Diagnosis: F40.231(needle phobia)
☐ Other ICD-10/Diagnosis: _____

B

Recommended to check additional strengths for titration needs

☐ **MYCAPSSA 40 mg**
Starting Dose
Dispense:
MYCAPSSA 20 mg capsules Sig: Take 1 capsule PO BID
☐ **QTY:** 56
☐ **QTY:** 168
Number of Refills_____

☐ **MYCAPSSA 60 mg**
Dispense:
MYCAPSSA 20 mg capsules Sig: Take 2 capsule PO QAM and 1 capsule PO QPM
☐ **QTY:** 84
☐ **QTY:** 252
Number of Refills_____

☐ **MYCAPSSA 80 mg**
Dispense:
MYCAPSSA 20 mg capsules Sig: Take 2 capsule PO BID
☐ **QTY:** 112
☐ **QTY:** 336
Number of Refills_____

PRESCRIBER AUTHORIZATION* (mandatory)

By signing below, I certify that I am part of the Chiesi Total Care Program, that the therapy described above is medically necessary, and that the information provided is accurate to the best of my knowledge. I also attest that I have obtained the patient's authorization to release the above information and such other personal information as may be necessary to the Chiesi Total Care Program and/or their agents. If the patient is 18 years old or younger, I attest that I have obtained permission from the patient's legal guardian.

Licensed Prescriber Signature (required–no stamps) _____

Printed Name _____ Date _____

ATTENTION: E-prescribe or use the official state prescription form where required by state law.
No stamped signatures or signing on behalf of the prescriber.

Scan for digital RX form.

Product: MYCAPSSA®

Phone: 1-833-346-2277

…SA, Inc. ("Chiesi") product. Program support may include:
… and reviewing eligibility for financial assistance and copay
…, and (4) providing disease-, medication-, and adherence-

… (MM/DD/YY): _____

…RE

…iesi USA, Inc., and its affiliates, service providers, agents,
…viders, and their staff, my health plan, patient assistance
…out my diagnosis, treatment, and lab results), personal
…as prescriptions and plans) (together my "Information") in
…duct other business activities, and complete government
…tives (together, "Chiesi") including providers of alternate
…Program") for Healthcare Providers and patients for the
… mail, phone, email, and text message*), tailor Program-
…pense Chiesi products to me. Chiesi may also de-identify
…usiness purposes. I understand that once my Information
…ever, Chiesi will only process and disclose my Information
…w.chiesiusa.com/privacy-policy/.

…l Care Program, you understand that Chiesi USA, Inc. may
…s://www.chiesiusa.com/privacy-policy/. To opt-out of the use
…87. Only you, or someone legally authorized to act on your
… defined in the California Consumer Privacy Act ("CCPA").

…affect my treatment, insurance coverage, or eligibility for

… letter requesting cancellation to Chiesi Total Care, 8517
…d personal data rights, Chiesi will no longer process my
…d on this Authorization prior to receipt of the cancellation.
…quired by state or local law.

…n to Chiesi. I acknowledge that if I am eligible for infusion
…knowledge that if I am enrolled in a government-funded
…stand and agree that if my insurance information changes
…ossible, and any such change may affect my eligibility for

…tal Care support programs on page 2 of this document.

…esi about opportunities for you to provide feedback to us

…vide feedback.

…consent to receiving text messages is not a condition of
…ext messages by replying STOP to any text from Chiesi

…ges.

…ate (MM/DD/YY):_____

… to Patient:_____

…and I agree that Chiesi Total Care will not pay those fees.

_____

_____

Office Contact Person:_____ **Office Phone:**_____

IMPORTANT SAFETY INFORMATION

ADVERSE REACTIONS

The most common adverse reactions (incidence >10%) are nausea, diarrhea, headache, arthralgia, asthenia, hyperhidrosis, peripheral swelling, blood glucose increased, vomiting, abdominal discomfort, dyspepsia, sinusitis, and osteoarthritis.

Please see additional Important Safety Information throughout and accompanying full Prescribing Information.

Specify appropriate ICD-10 Diagnosis code(s) for secondary diagnosis

(Other uses are at prescriber's discretion)

A

ICD-10 Diagnosis Codes	
Diagnosis	**Current indication**
E22.0	Acromegaly and pituitary gigantism
D35.2	Benign neoplasm of the pituitary gland
F40.231	Needle phobia

Intended as a reference for coding and billing for product and associated services. Not intended to be a directive, nor does the use of the recommended codes guarantee reimbursement. Providers are responsible for ensuring the accuracy and validity of all billing and claims for appropriate reimbursement.

Specify formulation and dosing schedule

B

Start

Manage patients' expectations when starting MYCAPSSA

- Start patients on the 20 mg BID oral dose
- Ensure they take MYCAPSSA with a glass of water
- Coach them on finding a routine for taking MYCAPSSA on an empty stomach, either 1 hour before or 2 hours after eating

Titrate

- Titrate based on IGF-1 levels and patients signs and symptoms.
- Titrate in 20 mg increments from 40 mg up to a maximum daily dosage of 80 mg.
- Recommended to select additional strengths for titration needs.

Step 2: Once you have completed the form:

1. **Attach copies of patient insurance and prescription cards – front and back.**
2. **First prescription for the patient:**
   THE FIRST COPY OF THE FORM MUST BE FAXED FOR EACH PATIENT. Fax completed form to Chiesi Total Care℠ at **1-833-746-2277. PLEASE COMPLETE ONE FORM PER PATIENT.**
3. **Subsequent prescriptions:**
   If you wish to send additional forms via e-script please search for "AcariaHealth" in your EMR/HMR's e-prescribing software.

The fillable pdf can be downloaded and saved for future use.

Scan the QR code to download a copy.

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WARNINGS AND PRECAUTIONS

MYCAPSSA can cause problems with the gallbladder. Monitor patients periodically. Discontinue if complications of cholelithiasis are suspected.

Blood sugar, thyroid levels, and vitamin B_{12} levels should be monitored and treated accordingly.

Bradycardia, arrhythmia, or conduction abnormalities may occur. Treatment with drugs that have bradycardia effects may need to be adjusted.

ADVERSE REACTIONS

The most common adverse reactions (incidence >10%) are nausea, diarrhea, headache, arthralgia, asthenia, hyperhidrosis, peripheral swelling, blood glucose increased, vomiting, abdominal discomfort, dyspepsia, sinusitis, and osteoarthritis.

DRUG INTERACTIONS

The following drugs require monitoring and possible dose adjustment when used with MYCAPSSA: cyclosporine, insulin, antidiabetic drugs, calcium channel blockers, beta blockers, lisinopril, digoxin, bromocriptine, and drugs mainly metabolized by CYP3A4. Counsel women taking an oral contraceptive to use an alternative non-hormonal method of contraception or a back-up method when taking MYCAPSSA.

Patients taking proton pump inhibitors, H2-receptor antagonists, or antacids concomitantly with MYCAPSSA may require increased dosages of MYCAPSSA.

PREGNANCY

Advise premenopausal females of the potential for an unintended pregnancy.

To report SUSPECTED ADVERSE REACTIONS, please contact Chiesi Farmaceutici S.p.A. at 1-888-661-9260 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

References: 1. Mycapssa® (octreotide) Prescribing Information. Amryt, March 2022.

For more information, visit mycapssa.com.
Chiesi Total Care℠ Program offered through AcariaHealth Specialty Pharmacy.

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