Prescription Form

To Be Completed by Prescriber

Chiesi TOTAL care℠

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

☐ **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: _____

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.

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.

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

Chiesi Total Care Program offered through AcariaHealth Specialty Pharmacy.

CHIESI TOTAL CARE

PHONE
1-833-346-2277

HOURS OF OPERATION
Monday to Friday
7:00am - 7:00pm (Central Time)

FAX
1-833-746-2277

WEBSITE
chiesitotalcare.com

For more information, visit mycapssa.com.

PP-MC-0028 V1.0

Mycapssa®
(octreotide) capsules 20mg