

1. First prescription for the patient: Fax completed form to 1-833-746-2277 or submit completed form online at <https://chiesitotalcarehcp.iassist.com>
2. Subsequent prescription: May be e-script via **AcariaHealth Specialty Pharmacy**
Call 1-833-346-2277 if you have questions regarding this form

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

Patient Name (First, Middle, Last) _____ Email _____
Last 4 of Social Security # _____ Sex 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 Title _____ Prescriber NPI # _____
Prescriber Tax ID # _____ Facility Name _____
Address _____ City _____ State _____ Zip _____
Phone # _____ Preferred Fax # _____
Primary Contact Name _____ Title/Role _____
Primary Contact Phone # _____ Primary Contact Email _____

4: PRESCRIPTION ORDER (mandatory)

Rx Treatment: MYCAPSSA® (octreotide) delayed-release oral capsules NDC: 10122-550-28. Dispense as written.
Please check a box below for medication strength (mandatory)

Mandatory: Check both columns

Recommended: Check additional strengths for titration needs

Patient, at any time, has received and tolerated 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)
 Other ICD-10/Diagnosis: _____

MYCAPSSA 40 mg
Recommended starting dose
Dispense:
MYCAPSSA 20 mg capsules
Sig: Take 1 capsule PO BID
 QTY: 56 (28-day supply)
 QTY: 168 (84-day supply)
Number of Refills _____

MYCAPSSA 60 mg
Dispense:
MYCAPSSA 20 mg capsules
Sig: Take 2 capsules PO QAM and 1 capsule PO QPM
 QTY: 84 (28-day supply)
 QTY: 252 (84-day supply)
Number of Refills _____

MYCAPSSA 80 mg
Dispense:
MYCAPSSA 20 mg capsules
Sig: Take 2 capsules PO BID
 QTY: 112 (28-day supply)
 QTY: 336 (84-day supply)
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 to
submit online
RX form



Scan to
download
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 B₁₂ 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.

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PP-MC-0028 V2.0



Mycapssa[®]
(octreotide) capsules
20mg