

1. First prescription for the patient: Fax completed form to **1-833-746-2277** or submit completed form online at **chiesitotalcare.iassist.com**
2. Subsequent prescription: May be e-script via **PANTHERx Rare PharmacySM**
Call **1-833-346-2277** if you have questions regarding this form

1 PATIENT INFORMATION (all fields in this section are mandatory unless otherwise stated)

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 _____
 Legal Representative (if applicable) _____ OK to leave message
 Email _____ Legal Representative Phone # (if applicable) _____
 Allergies _____ Current Medications _____
 No known drug allergies (NKDA)

2 PRESCRIPTION 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 their 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: 69880-120-28.
Please check a box below for medication strength (mandatory)

Mandatory: Check both columns

Patient, at any time, has responded to 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)

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)

Number of Refills _____

Mycapssa 80 mg

Dispense:
 Mycapssa 20 mg capsules
 Sig: Take 2 capsules PO BID

QTY: 112 (28-day supply)

Number of Refills _____

5 PRESCRIBER AUTHORIZATION Your signature authorizes the specialty pharmacy to dispense necessary medication associated with Mycapssa

By submitting this form, I certify that I am the prescribing provider mentioned above; that the person named on this form is my patient; that the information provided herein is, to the best of my knowledge, current, complete, and accurate; that the therapy described above is medically necessary for this patient and the patient's records contain supporting documentation that substantiates the utilization and medical necessity of the therapy; that I have prescribed the therapy to the patient; that the decision to prescribe the therapy was based solely on my independent medical judgment; and that I am authorized under state law to prescribe the therapy. I will be supervising the patient's treatment, and I have reviewed the current prescribing information for the therapy. Further, I certify that I have discussed Chiesi Total CareSM (the "Program") with my patient and that my patient would like to be screened for eligibility for the Program and provided, if applicable, any services under the Program for which my patient is eligible.

I understand that my patient's information provided to Chiesi, its successors, vendors, agents, and representatives (collectively, "Chiesi") is for the use of the Program to verify my patient's insurance coverage; to facilitate the filling of my patient's prescription; to assess my patient's eligibility for the Program and other support programs; and to otherwise administer the Program for the patient. I certify that I am disclosing the patient's Protected Health Information ("PHI") on this form to the Program for treatment, payment, or healthcare operations purposes, in accordance with the requirements under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, as amended ("HIPAA"). Additionally, I provide my permission to use my personal information for the purposes described above and certify that I have obtained the patient's written authorization in accordance with applicable state and federal law, including HIPAA, to provide the PHI on this form to the Program for such purposes. If my patient is 18 years old or younger, I attest that I have obtained such authorization from the patient's legal guardian. I acknowledge and agree that the Program may reach out to my patient to obtain additional consents or

authorizations as deemed appropriate in connection with the Program.

I authorize the Program to conduct a benefits investigation for my patient (and to act on my behalf for the limited purpose of transmitting this prescription to the appropriate pharmacy based on the results of that benefits investigation). If coverage is not available and the patient qualifies for and will receive free product under the Program, I understand that no request for reimbursement for free product or administration of such product may be submitted to any payer, including Medicare, Medicaid, and any government-funded programs. Receiving free product is not contingent on any purchase obligations, and no free product may be sold, traded, or distributed for sale. I understand that any falsification, omission, or concealment of material fact related to my patient's eligibility for such free product may result in criminal liability.

I consent to Chiesi contacting me by fax, mail, or email to provide additional information about the product(s) marked above or the Program. I understand that the Program may revise, change, or terminate any Program services at any time without notice to me.

PRESCRIBER'S SIGNATURE (dispense as written). Signature stamps not acceptable.



Date _____ (mm/dd/yyyy)

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.

IMPORTANT SAFETY INFORMATION

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.

New onset of steatorrhea, stool discoloration, loose stools, abdominal bloating, and weight loss may occur with Mycapssa and other somatostatin analogs. If new occurrence or worsening of these symptoms are reported, evaluate for potential pancreatic exocrine insufficiency and manage accordingly.

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.

Please report adverse events to Chiesi Farmaceutici S.p.A. at 1-888-661-9260 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Please see full Prescribing Information, including Medication Guide.

Chiesi Total Care Program offered through PANTHERx Rare Pharmacy.

CHIESI TOTAL CARE



PHONE
1-833-346-2277



HOURS OF OPERATION
Monday to Friday
8:00am - 8:00pm (Eastern Time)



FAX
1-833-746-2277



WEBSITE
chiesitotalcare.com

Scan to
submit online
RX form



Scan to
download
RX form



For more information, visit mycapssa.com.

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PP-MC-0028 V6.0



Mycapssa[®]
(octreotide) capsules
20mg