# Somatuline Depot (lanreotide acetate)

**Provider Order Form** *rev. 1/12/2026*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

## PATIENT INFORMATION

**Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

**Patient Status:** ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

**Patient Preferred Location:** _____

## DIAGNOSIS & CLINICAL INFORMATION

**ICD 10-Code & Description:** ICD-10 Code: _____ ICD-10 Description: _____

☐ Carcinoid syndrome
☐ Neuroendocrine tumors (NETs) of the gastrointestinal tract (GI), lung, and thymus (carcinoid tumors)
☐ Neuroendocrine tumors (NETs) of the pancreas (islet cell tumors), (including gastrinomas, glucagonomas, insulinomas and VIPomas)
☐ Gastroenteropancreatic neuroendocrine tumor (GEP-NETs)
☐ Paraganglioma Pheochromocytoma Zollinger-Ellison syndrome
☐ Other

**For Continuation Requests (clinical documentation required):**

☐ **Acromegaly:**
Please indicate how the patient's IGF-1 (insulin-like growth factor 1) level changed since initiation of therapy: ☐ Increased ☐ Decreased or normalized ☐ No change

☐ **Carcinoid syndrome**
☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

**Neuroendocrine tumors (NETs):** ☐ **NETs of gastrointestinal tract (GI), lung, and thymus (carcinoid tumors)** ☐ **NETs of pancreas (islet cell tumors), including gastrinomas, glucagonomas, insulinomas and VIPomas** ☐ **Gastroenteropancreatic NETs (GEP-NETs)**
☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ **Paraganglioma**
☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ **Pheochromocytoma**
☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ **Zollinger-Ellison syndrome**
☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by improvement or stabilization in clinical signs and symptoms since starting therapy?

☐ Other: _____

**REQUIRED DOCUMENTATION:** Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results ( CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☑ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

## PRESCRIPTION INFORMATION

**Nursing:** Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

**Pre-Medications**
☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
☐ Other: _____ Dose: _____ Route: _____

**Lab Orders**
*Required:* IGF-1 (insulin-like growth factor 1) levels
☐ Other: _____

**Therapy Order** (Select one):
**Rx:** Give Somatuline Depot (lanreotide) deep subcutaneous injection. Give into the superior external quadrant of the buttock.
**Dose:** Somatuline Depot (lanreotide): ☐ 60 mg ☐ 90 mg ☐ 120 mg ☐ 180 mg ☐ Somatuline _____ mg
**Frequency:** ☐ Every 4 weeks ☐ Every 6 weeks ☐ Every 8 weeks ☐ Other _____
**Duration:** ☐ 3 months ☐ 6 months ☐ 1 year ☐ Other _____

**Post Treatment Observations:** The patient is required to stay for 30 minutes following the first administration.
☐ **Refills:** ☐ zero ☐ 6 months ☐ 12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*
**Special Instructions:** _____

## PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

*Provider Name (Print)* *Provider Signature* *Date*


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**McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454**
**Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213**
**Other Locations** (Oaklawn, Lancaster, etc)**: F: 469.305.2361 P: 972.865.4454**