MPP INFUSION CENTERS
www.mppinfusion.com

Fax Referrals To: (855) 891-2191
Email Referrals To: MPPReferral@mppinfusion.com
Have a Question? (855) 478-1528

CORTROSYN® (cosyntropin) ORDER FORM

(- Required Fields)*

____ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

____ **New Referral** ____ **Order Renewal** ____ **Medication/Order Change**
____ **Benefits Verification Only** ____ **Discontinuation Order**

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: ☐M ☐F
ADDRESS:		PHONE:	
WEIGHT: ☐LBS ☐KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

CORTROSYN ORDER*:

ICD-10*: _____

____ Baseline blood draw followed by 0.25 mg IV push followed by:

___ Blood draw 30 minutes post IV push

OR

____ Blood draw 30 and 60 minutes post IV push

Physician Signature* _____ **Date*(Order is Valid for One Year)** _____
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

____ Primary or secondary adrenal insufficiency

____ Other_____

***STAT REASON:**
(STAT request will be assessed per MP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

____ Patient Demographics
____ Insurance Card/Information
____ Clinical/Progress Notes supporting DX
____ Current Medication List and H&P

Last Infusion/Injection Date: _____

NOTES/ADDITIONAL COMMENTS:

Locations:

--------Colorado--------
___ Lakewood

---------Florida---------
___ Jacksonville
___ Kissimmee
___ Port St. Lucie
___ Suncoast
___ Winter Park

--------Oklahoma----------
___ Tulsa

----------Texas----------
___ Arlington
___ Cedar Hill
___ Dallas
___ Denton
___ Ft. Worth
___ Irving
___ Rockwall
___ Southlake
___ Flowe Mound
___ Plano
___ Tyler

9/2021