SALIX ENROLLMENT FORM

PATIENT INFORMATION

Last Name _____ First Name _____

Social Security No _____ Date of Birth _____

Sex □ M □ F Weight_____ Height_____ Allergies_____

Home Phone _____ Work/Mobile _____

Home Address _____

City _____ State _____ Zip _____

PATIENT INSURANCE INFORMATION

Primary Medical Insurance _____ Medical Insurance Phone _____

Subscriber Name _____

Rx Card (PBM) _____ Group No _____

Prescription Card Bin # _____ PCN # _____

TREATMENT ARRANGEMENTS

•Start Date:_____ Ship Meds □ Home □ Doctor's Office

STATEMENT OF MEDICAL NECESSITY

DIAGNOSIS:

□ IBS-D (K 58.0) □ Travelers diarrhea (A09) □ Hepatic Encephalopathy (K 72.90) □ Ulcerative Colitis (K 51.40)

□ Other: _____ Date of Diagnosis: _____ Prior Medications: _____ □ **NKDA**

PRESCRIPTION INFORMATION

DRUG	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
□ **PLENVU**	□ 1Kit	□ Use as directed. □ Others :		
□ **LUCEMYRA**	□ 0.18mg	□ Take 3 tabs by mouth QID days 1-7, take 2 tabs by mouth QID on day 8 and take 1 tab by mouth QID on day 9 with or without food. □ Others :		
□ **XIFAXAN (HE)**	□ 550mg	□ Take one tablet by mouth BID with or without food as directed. □ Others :	**60**	
□ **XIFAXAN (IBS-D)**	□ 550mg	□ Take one tablet by mouth TID for 14 days with or without food as directed. □ Others :	**42**	
□ **UCERIS**	□ 9mg	□ Take one tablet by mouth Once a day. □ Others :		
□ **RELISTOR**	□ 150mg	□ Take 3 tablets by mouth every morning 30 minutes prior to breakfast. □ Others :		
□ **TRULANCE**	□ 3mg	□ Take one tablet by mouth Once a day. □ Others :	**90**	

Physician Signature: X_____ □ **DAW (Dispense as Written) Date:** _____

Physician Name: _____ **Phone:** _____ **Fax:** _____ **Office Contact:** _____

Physician Address: _____ **NPI:** _____ **DEA:** _____

By Signing this enrollment form you authorize Southside Pharmacy to call Insurance companies on behalf of you for prior authorization purposes.

FAX TO 747-900-8489

South Side WINNETKA PHARMACY
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