

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
<input type="checkbox"/> PLENVU	<input type="checkbox"/> 1Kit	<input type="checkbox"/> Use as directed. <input type="checkbox"/> Others :		
<input type="checkbox"/> LUCEMYRA	<input type="checkbox"/> 0.18mg	<input type="checkbox"/> 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. <input type="checkbox"/> Others :		
<input type="checkbox"/> XIFAXAN (HE)	<input type="checkbox"/> 550mg	<input type="checkbox"/> Take one tablet by mouth BID with or without food as directed. <input type="checkbox"/> Others :	60	
<input type="checkbox"/> XIFAXAN (IBS-D)	<input type="checkbox"/> 550mg	<input type="checkbox"/> Take one tablet by mouth TID for 14 days with or without food as directed. <input type="checkbox"/> Others :	42	
<input type="checkbox"/> UCERIS	<input type="checkbox"/> 9mg	<input type="checkbox"/> Take one tablet by mouth Once a day. <input type="checkbox"/> Others :		
<input type="checkbox"/> RELISTOR	<input type="checkbox"/> 150mg	<input type="checkbox"/> Take 3 tablets by mouth every morning 30 minutes prior to breakfast. <input type="checkbox"/> Others :		
<input type="checkbox"/> TRULANCE	<input type="checkbox"/> 3mg	<input type="checkbox"/> Take one tablet by mouth Once a day. <input type="checkbox"/> Others :	90	

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

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

Physician Address: _____ NPI: _____ DEA: _____

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