GENERAL GI 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:

□ Hepatic Encephalopathy (K 72.90) □ IBS-D (K 58.0) □ IBS-C (K 58.1) □ Travelers diarrhea (A09)

□ Ulcerative Colitis (K51.40) □ Crohn's Disease (K50.00) □ Chronic Idiopathic Constipation (CIC) (K59.04)

Date of Diagnosis: _____ Prior Medications: _____

PRESCRIPTION INFORMATION

HEPATIC ENCEPHALOPATHY (HE)

□ **XIFAXAN 550 mg**
ONE 550 mg Tablet 2 times a day.
Quantity: 60 Refills: ____

Ulcerative Colitis (UC) & Cohn's Treatments

□ **UCERIS 9 mg**
ONE Tablet by mouth ONCE a day.
Quantity: ___ Refills: ____

□ **Entocort EC 3 mg**
Take THREE Capsule (9mg) by mouth ONCE a day.
Quantity: ___ Refills: ____

□ APRISO 0.375 gm □ ASACOL HD 800 mg □ LIALDA 1.2 gm
□ PENTASA 500 mg □ CANASA 1000 mg □ _____
Directions: _____
Quantity: _____ Refill:_____

IBS- D, IBS-C & CIC Treatments

□ **XIFAXAN 550 mg**
ONE 550 mg Tablet 3 times a day for 14 days.
Quantity: 42 Refills: ____

□ **VIBERZI 100 mg** □ **VIBERZI 75 mg**
Take ONE tablet by mouth TWICE daily.
Quantity: ____ Refills: ____

□ **TRULANCE 3 mg**
Take ONE Tablet by mouth ONCE daily.
Quantity: 30 Refills: _____

□ **LINZESS 72 mcg** □ **LINZESS 145 mcg** □ **LINZESS 290 mcg**
Take ONE CAPSULE by mouth ONCE daily.
Quantity: 30 Refills: _____

□ **AMITIZA 8 mcg** □ **AMITIZA 24 mcg**
Take ONE CAPSULE by mouth TWICE daily.
Quantity: 60 Refills: _____

□ **ALINIA 500 mg Tablet** □ **ALINIA Suspension** Directions:_____ Quantity: _____ Refills: _____

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 your referral to (470) 377-4055

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