

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 ARRANGMENTS

•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: _____

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