

## IBS / BOWL - ENROLLMENT FORM

### PATIENT INFORMATION

Name (First, Last): \_\_\_\_\_ ☐ Male ☐ Female  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Date of Birth: (mm/dd/yyyy) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security# \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_

**PLEASE FAX COPY OF INSURANCE CARD, CHART NOTES AND LABS**

Medication	Dose/Strength	SIG	Quantity	Refills
<input type="checkbox"/> XIFAXAN	<input type="checkbox"/> 550 mg	<input type="checkbox"/> 1 tablet by mouth three times daily for 14 days (IBS-D) <input type="checkbox"/> 1 tablet by mouth twice daily ((hepatic encephalopathy))	<input type="checkbox"/> 42 <input type="checkbox"/> 60 <input type="checkbox"/> 180	
<input type="checkbox"/> RELISTOR	<input type="checkbox"/> 150 mg	<input type="checkbox"/> 3 tabs twice daily with water on an empty stomach at least 30 minutes before the first meal of the day	<input type="checkbox"/> 90 <input type="checkbox"/> 270	
<input type="checkbox"/> VIBERZI	<input type="checkbox"/> 75 mg <input type="checkbox"/> 100 MG	<input type="checkbox"/> 1 tablet by mouth twice daily with food	<input type="checkbox"/> 60	
<input type="checkbox"/> TRULANCE	<input type="checkbox"/> 3 mg	<input type="checkbox"/> 1 tablet by mouth once daily	<input type="checkbox"/> 30 <input type="checkbox"/> 90	
<input type="checkbox"/> LINZESS	<input type="checkbox"/> 72 mg <input type="checkbox"/> 145mg <input type="checkbox"/> 290 mg	<input type="checkbox"/> 1 tablet by mouth once daily	<input type="checkbox"/> 30 <input type="checkbox"/> 90	

#### Diagnosis (ICD10):

- ☐ K58.0 : IBS-Diarrhea  
☐ K58.1: IBS-Constipation  
☐ K72.90 : Hepatic Encephalopathy  
☐ K59.03 : Constipation, Opioid-Induced  
☐ K59.04 : Chronic Idiopathic Constipation  
☐ \_\_\_\_\_ ICD10:(\_\_\_\_)

#### Order Status and Special Instructions:

- ☐ URGENT ORDER (STAT)  
☐ Send to RX to MD office

#### Previously tried/failed therapies & dates:

- |  |                          |
|--|--------------------------|
| <input type="checkbox"/> Amitiza                   | Date: ____ / ____ / ____ |
| <input type="checkbox"/> Linzess                   | Date: ____ / ____ / ____ |
| <input type="checkbox"/> Lactulose                 | Date: ____ / ____ / ____ |
| <input type="checkbox"/> Metronidazole             | Date: ____ / ____ / ____ |
| <input type="checkbox"/> Neomycin                  | Date: ____ / ____ / ____ |
| <input type="checkbox"/> Loperamide                | Date: ____ / ____ / ____ |
| <input type="checkbox"/> Cholestyramine            | Date: ____ / ____ / ____ |
| <input type="checkbox"/> Colestipol                | Date: ____ / ____ / ____ |
| <input type="checkbox"/> Dicyclomine               | Date: ____ / ____ / ____ |
| <input type="checkbox"/> Hyoscyamine               | Date: ____ / ____ / ____ |
| <input type="checkbox"/> Tricyclic Antidepressants | Date: ____ / ____ / ____ |
| <input type="checkbox"/> SSRI                      | Date: ____ / ____ / ____ |
| <input type="checkbox"/> Other Therapies _____     |                          |

Total # of Dangerous Drugs Prescribed \_\_\_\_\_

### PRESCRIBER'S INFORMATION

Prescriber Name (First, Last): \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Address: \_\_\_\_\_ DEA #: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Contact Name: \_\_\_\_\_  
 Physician Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*I authorize 986 Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process*

IMPORTANT NOTICE: This facsimile is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.