986 PHARMACY SPECIALTY

1719 E. Walnut St Pasadena, CA 91106
Phone 626-798-6789 Fax 626-798-8376

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
☐ **XIFAXAN**	☐ 550 mg	☐ 1 tablet by mouth three times daily for 14 days (IBS-D) ☐ 1 tablet by mouth twice daily ((hepatic encephalopathy)	☐ 42 ☐ 60 ☐ 180	
☐ **RELISTOR**	☐ 150 mg	☐ 3 tabs twice daily with water on an empty stomach at least 30 minutes before the first meal of the day	☐ 90 ☐ 270	
☐ **VIBERZI**	☐ 75 mg ☐ 100 MG	☐ 1 tablet by mouth twice daily with food	☐ 60	
☐ **TRULANCE**	☐ 3 mg	☐ 1 tablet by mouth once daily	☐ 30 ☐ 90	
☐ **LINZESS**	☐ 72 mg ☐ 145mg ☐ 290 mg	☐ 1 tablet by mouth once daily	☐ 30 ☐ 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:

- ☐ Amitiza Date:_____/_____/_____
- ☐ Linzess Date:_____/_____/_____
- ☐ Lactulose Date:_____/_____/_____
- ☐ Metronidazole Date:_____/_____/_____
- ☐ Neomycin Date:_____/_____/_____
- ☐ Loperamide Date:_____/_____/_____
- ☐ Cholestyramine Date:_____/_____/_____
- ☐ Colestipol Date:_____/_____/_____
- ☐ Dicyclomine Date:_____/_____/_____
- ☐ Hyoscyamine Date:_____/_____/_____
- ☐ Tricyclic Antidepressants Date:_____/_____/_____
- ☐ SSRI Date:_____/_____/_____
- ☐ 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