GI IBS Referral Form

1. Patient Information

Patient Name: _____ Birthdate: _____ Sex: ☐ Male ☐ Female Weight_____ ☐ lbs. ☐ kg

Preferred Phone: _____ Known Allergies_____

Address: _____ City: _____ State_____ Zip: _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2. Prescriber Information

Prescriber Name: _____ NPI#_____ Tax ID#_____

Address: _____ Phone: _____ Fax: _____

City, State, Zip: _____ Key Contact: _____

3. Diagnosis/Clinical Information

Diagnosis:_____ ICD-10: _____

Prior Failed Medications: (medication and duration of treatment/reason for d/c) Other: _____

☐ Fiber

☐ Osmotic Laxative ☐ antisposmodic ☐ antidepressants

☐ anti-diarrheal agents ☐ antibiotics

☐ probiotics

Please FAX recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

4. Prescription Information

Medication	Dose/Strength	Sig	QTY.	Refills
☐ Amitiza® ☐ Women only	☐ 8 mcg tablets ☐ 24 mcg tablets	☐ Take 8 mcg by mouth twice daily ☐ Take 24 mcg by mouth twice daily		
☐ Linzess	☐ 72 mcg ☐ 145 mcg ☐ 290 mcg	☐ Take 1 tablet by mouth once daily		
☐ Loperamide	☐ 2mg capsule	☐ Take 2 capsules by mouth, followed by 1 capsule after each unformed stool. (max 16mg/24h)		
☐ Lotronex® ☐ Women only	☐ 0.5 mg ☐ 1 mg	☐ Take 0.5 mg by mouth twice daily for 4 weeks ☐ If tolerated, but response is inadequate, may be increased after 4 weeks to 1 mg twice daily (maximum dose: 2 mg/day) ☐ Take 1 mg by mouth twice daily		
☐ Motegrity	☐ 1mg tablet ☐ 2mg tablet	☐ Take 1 tablet by mouth once daily		
☐ Movantik	☐ 12.5mg tablet ☐ 25mg tablet	☐ Take 1 tablet by mouth in the morning		
☐ Relistor	☐ 150mg tablet ☐ 8mg/0.4mL SQ ☐ 12mg/0.6mL SQ	☐ Take 450mg (3 tablets) once in the morning ☐ Inject 12mg SQ once daily in the morning		
☐ Symproic	☐ 0.2mg tablet	☐ Take 1 tablet by mouth daily		
☐ Trulance	☐ 3mg tablet	☐ Take 1 tablet by mouth daily		
☐ Viberzi	☐ 75mg tablet ☐ 100mg tablet	☐ Take 1 tablet by mouth twice daily with food		
☐ Xifaxan®	☐ 200 mg tabs ☐ 550 mg tabs	☐ Take 550 mg by mouth 3 times per day for 14 days ☐ other:		
☐ Zelnorm ☐ Women only	☐ 6mg tablet	☐ Take 1 tablet by mouth twice daily at least 30 minutes before meals for 4-6 weeks		
☐ Isbrela	☐ 50 mg tablet	☐ Take 1 tablet by mouth twice a day		

Dispensing Options: ☐Patient ☐ Prescriber's Office

Prescriber Signature: Prescriber, please sign and date below	
Dispense as Written Date	Substitution Permitted Date

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

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.