Gastroenterology Enrollment Form

VALUE SPECIALTY PHARMACY

Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Alternate Caregiver Name/Phone: _____

Sex: ❑ Male ❑ Female Height: _____ Weight: _____ lbs kg
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Patient Email: _____

Ins. Data

Primary Insurance: _____
Policy: _____ Group#: _____

Secondary Insurance: _____
Policy: _____ Group#: _____

❑ ***Patient has commercial insurance and authorizes pharmacy to apply for manufacturer copay card. Email must be provided above.***

Diagnosis and Clinical Information

To expedite prior authorization, please attach clinical office notes, and past treatment history.

❑ K58.0 Irritable bowel syndrome with predominant diarrhea
- Has patient had an inadequate treatment response to dietary modification such as low carbohydrate diet, exclusion of gas producing foods, or lactose free diet if intolerant? ❑ Yes ❑ No
- Does patient have an intolerance or contraindication or have an inadequate treatment response to anti-diarrheal medication? ❑ Yes ❑ No
  - If yes, please list past tried and failed therapies: _____

❑ K58.1 Irritable bowel syndrome with constipation
- Does patient have a gastrointestinal obstruction? ❑ Yes ❑ No
- Does patient have an intolerance or contraindication or have an inadequate treatment response to bulk forming laxative? ❑ Yes ❑ No
- Does patient have an intolerance or contraindication or have an inadequate treatment response to stimulant laxative? ❑ Yes ❑ No
- Does patient have an intolerance or contraindication or have an inadequate treatment response to osmotic laxative? ❑ Yes ❑ No
  - If yes to any of the above, please list past tried and failed therapies: _____

❑ K63.821 Small Instestinal Bacterial Overgrowth (SIBO)
- Has patient had an inadequate treatment response to dietary modification such as low carbohydrate diet, exclusion of gas producing foods, or lactose free diet if intolerant? ❑ Yes ❑ No
- Does patient have intolerance or contraindication or have an inadequate treatment response to another antibiotic for SIBO? ❑ Yes ❑ No
  - If yes, please list past tried and failed therapies: _____

❑ K76.82 Hepatic Encephalopathy
- Has patient had an inadequate treatment response to other medications? ❑ Yes ❑ No
  - If yes, please list past tried and failed therapies: _____

❑ R11.2 Traveler's Diarrhea
- Is patient experiencing Traveler's Diarrhea caused by noninvasive strains of Escherichia coli (E coli)? ❑ Yes ❑ No
- Will medication be used in combination with another medication for Traveler's Diarrhea? ❑ Yes ❑ No
  - If yes, please medications: _____

❑ Other Diagnosis: _____ ICD 10: _____
- Has patient had an inadequate treatment response to other medications? ❑ Yes ❑ No
  - If yes, please list past tried and failed therapies: _____

Prescription

Medication	Strength	Directions	Quantity	Refills
❑ Ibsrela®	50mg tablet	Take 1 tablet orally twice daily prior to meal	#60	
❑ Xifaxan®	❑ 200mg tablet *Traveler's Diarrhea*	Take 1 tablet orally three times daily for 3 days	#9	0 refills
	❑ 550mg tablet *Hepatic Encephalopathy*	Take 1 tablet orally twice daily	#60	
	❑ 550mg tablet *IBS-D*	Take 1 tablet orally three times daily for 14 days	#42	

Is patient new to this therapy: ❑ YES ❑ NO | **Ship to:** ❑ Patient ❑ Office ❑ Other | **Need by Date:** _____

Prescriber Data

Prescriber Name: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DEA#: _____ NPI: _____
Contact: _____
Phone: _____ Fax: _____
Key Contact#: _____

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____

This prescription will be filled generically unless prescriber writes **"DAW"** in the box to the right.