Gastrointestinal Disorders Enrollment Form

PATIENT INFORMATION

Patient Name: _____
Date of Birth: ____ /____ / ____ ☐ Male ☐ Female
SSN: ____ -____ - ____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (____) - ____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: ____ /____ / ____
Allergies: Medications:

(Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____
Clinic/Hospital Affiliation: _____

Phone: (____) - ____ - _____
Fax: (____) - ____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

GIRX-19-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ K58.1 Irritable bowel syndrome with constipation
☐ K59.03 Drug induced constipation
☐ K59.04 Chronic idiopathic constipation
☐ Other: _____

History of therapies tried/failed:
(please include names and dates)

Immunization History
☐ Influenza
Date: ____ /____ / ____

R_x

Medication	Dose/Strength	Directions	Quantity	Refills
Amitiza® (lubiprostone)	☐ 8 mcg capsules ☐ 24 mcg capsules	☐ Take 8 mcg by mouth twice daily ☐ Take 24 mcg by mouth twice daily		
Linzess® (linaclotide)	☐ 72 mcg capsules ☐ 145 mcg capsules ☐ 290 mcg capsules	☐ Take 72 mcg by mouth once daily ☐ Take 145 mcg by mouth once daily ☐ Take 290 mcg by mouth once daily		
Movantik® (naloxegol)	☐ 12.5 mg tablets ☐ 25 mg tablets	☐ Take 12.5 mg by mouth once daily ☐ Take 25 mg by mouth once daily		
Relistor® (methylnaltrexone)	☐ 150 mg tablets ☐ 8 mg pre-filled syringe ☐ 12 mg pre-filled syringe	☐ Take 450 mg (three 150 mg tablets) by mouth once daily ☐ Take 8 mg subcutaneously every other day as needed ☐ Take 12 mg subcutaneously every other day as needed ☐ Take 12 mg subcutaneously once daily as needed ☐ Other: _____		

Injection Training

Injection training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____