Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Prescriber
☐ Nursing needed; ☐ Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

ALTERNATIVE GASTROENTEROLOGY REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐ M ☐ F ☐ Other:	Weight:	☐ lbs. ☐ kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **Please attach demographic information**		

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone: Fax:	Key Office Contact:		Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: (ICD-10 Code & Description): _____

- Has patient been diagnosed with ☐ Irritable Bowel Syndrome (IBS), ☐ IBS with Diarrhea (IBS-D), or ☐ Invasive Bladder Cancer ☐ EoE ☐ PBC
- Please list ALL MEDS below that patient has tried and failed for dx including: (OTC, Motility Agent, Antispasmodic, Tricyclic Antidepressants)
- Other medications patient is currently taking with dosage and direction (or fax medication profile): _____

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

Dificid® ☐ **200 mg tablet**
200 mg PO BID for 10 days, with or without food — QTY: 20 | Refills: 0

Dupixent® ☐ **300 mg** *(for adults and children ≥ 40 kg)* ☐ Pen ☐ Syringe
Inj 300 mg SQ once weekly — QTY: 4 | Refills:

Dupixent® ☐ **200 mg** *(for children, 15-30 kg)* ☐ Pen (age: 2+) ☐ Syringe (age 1+)
Inj 200 mg SQ once every other week — QTY: 2 | Refills:

Dupixent® ☐ **300 mg** *(for children, 30-40 kg)* ☐ Pen (age: 2+) ☐ Syringe (age 1+)
Inj 300 mg SQ once every other week — QTY: 2 | Refills:

Iqirvo® ☐ **80 mg tablet**
Take 1 tablet PO once daily with or without food — QTY: | Refills:

Ocaliva® ☐ **5 mg tablet** ☐ **10 mg tablet**
take 1 tablet po once daily — QTY: 30 | Refills:

Xifaxan® ☐ **550 mg tablet** **If recurrence occurs then patient can be retreated up to 2 times with the same regimen for IBS-D*
☐ 550 mg PO TID for 14 days — QTY: 42 | Refills:
☐ 550 mg PO BID — QTY: 60 | Refills:

☐ **Other:** _____ QTY: | Refills:

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.

Rev: 06.14.24