

Phone: 800.511.5144 • Fax: 877.541.1503

**ALTERNATIVE GASTROENTEROLOGY
REFERRAL FORM**

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight:	<input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	<input type="checkbox"/> 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): _____					
<input type="checkbox"/> Has patient been diagnosed with <input type="checkbox"/> Irritable Bowel Syndrome (IBS), <input type="checkbox"/> IBS with Diarrhea (IBS-D), or <input type="checkbox"/> Invasive Bladder Cancer <input type="checkbox"/> Please list ALL MEDS below that patient has tried and failed for dx including: (OTC, Motility Agent, Antispasmodic, Tricyclic Antidepressants) <input type="checkbox"/> Other medications patient is currently taking with dosage and direction (or fax medication profile): _____					
INSURANCE INFORMATION					
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)					
COPAY CARD ENROLLMENT					
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID: _____			
PRESCRIPTION INFORMATION					
<input type="checkbox"/> Dificid® 200mg tablet		<input type="checkbox"/> 200 mg PO BID for 10 days, with or without food		QTY: <u> 20 </u>	Refills: <u> 0 </u>
<input type="checkbox"/> Dupixent® 300mg <input type="checkbox"/> Pen <input type="checkbox"/> Prefilled Syringe		<input type="checkbox"/> 300 mg SQ once weekly		QTY: <u> 4 </u>	Refills: <u> </u>
<input type="checkbox"/> Xifaxan® 200 mg tablet		<input type="checkbox"/> 200 mg PO TID for 3 days		QTY: <u> 9 </u>	Refills: <u> </u>
<input type="checkbox"/> Xifaxan 550 mg tablet <i>*if recurrence occurs then patient can be retreated up to 2 times with the same regimen for IBS-D</i>		<input type="checkbox"/> 550 mg PO TID for 14 days		QTY: <u> 42 </u>	Refills: <u> </u>
		<input type="checkbox"/> 550 mg PO BID		QTY: <u> </u>	Refills: <u> </u>
<input type="checkbox"/> Other: _____				QTY: <u> </u>	Refills: <u> </u>

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.

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