

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: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other:	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:
Phone:	Fax:	Key Office Contact:	Phone:

**DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT**

**Primary Diagnosis:** (ICD-10 Code & Description): \_\_\_\_\_

- Has patient been diagnosed with  Hepatic Encephalopathy  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**

<b>Dificid®</b>	<input type="checkbox"/> <b>200 mg Tablet</b> (for adults and children > 12.5 kg) Take 200 mg PO BID for 10 days, with or without food	QTY: _____	20	Refills: _____	0
<b>Dupixent®</b>	<input type="checkbox"/> <b>300 mg</b> (for adults and children ≥ 40 kg) <input type="checkbox"/> Pen <input type="checkbox"/> Syringe Inj 300 mg SQ once weekly	QTY: _____	4	Refills: _____	
<b>Dupixent®</b>	<input type="checkbox"/> <b>200 mg</b> (for children 15 to < 30 kg) <input type="checkbox"/> Pen (age: 2+) <input type="checkbox"/> Syringe (age 1+) Inj 200 mg SQ once every other week	QTY: _____	2	Refills: _____	
<b>Dupixent®</b>	<input type="checkbox"/> <b>300 mg</b> (for children 30 to < 40 kg) <input type="checkbox"/> Pen (age: 2+) <input type="checkbox"/> Syringe (age 1+) Inj 300 mg SQ once every other week	QTY: _____	2	Refills: _____	
<b>Eohilia™</b>	<input type="checkbox"/> <b>2 mg/10 mL Packet</b> Take 1 packet (2 mg) PO twice daily for 12 weeks	QTY: #60 Packets/30 DS		Refills: _____	2
<b>lqirvo®</b>	<input type="checkbox"/> <b>80 mg Tablet</b> Take 1 tablet PO once daily with or without food	QTY: _____	30	Refills: _____	
<b>Ocaliva®</b>	<input type="checkbox"/> <b>5 mg Tablet</b> <input type="checkbox"/> <b>10 mg Tablet</b> Take 1 tablet po once daily	QTY: _____	30	Refills: _____	
<b>Xifaxan®</b>	<input type="checkbox"/> <b>550 mg Tablet</b> *if recurrence occurs then patient can be retreated up to 2 times with the same regimen for IBS-D <input type="checkbox"/> Take 550 mg PO TID for 14 days <input type="checkbox"/> Take 550 mg PO BID	QTY: _____	42	Refills: _____	
		QTY: _____	60	Refills: _____	
<input type="checkbox"/> <b>Other:</b>	_____	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.