AcariaHealth
Specialty Pharmacy

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	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 ASSESMENT

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

- Has patient been diagnosed with ☐Irritable Bowel Syndrome (IBS), ☐IBS with Diarrhea (IBS-D), or ☐Invasive Bladder Cancer
- 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® ☐200mg tablet
☐200 mg PO BID for 10 days, with or without food — QTY: 20 Refills: 0

Dupixent® ☐300mg Pen ☐300mg Prefilled Syringe (for EoE)
☐300 mg SQ once weekly — QTY: 4 Refills: ____

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

Xifaxan® ☐200 mg tablet
☐200 mg PO TID for 3 days — QTY: 9 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: ____ 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.