PALMETTO PHARM
USE AS WRITTEN

Phone: 1-800-275-0139 • Fax: 843-972-9395

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

❑ **Alinia® 500 mg tablet**
- ❑ 500 mg PO every 12 hours for 3 days — QTY:_____ Refills:_____

❑ **Amitiza®**
- ❑ 8 mcg PO BID with food and water — QTY:_____ Refills:_____
- ❑ 24 mcg PO BID with food and water — QTY:_____ Refills:_____

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

❑ **Linzess®**
- ❑ 72 mcg PO daily — QTY:_____ Refills:_____
- ❑ 145 mcg PO daily — QTY:_____ Refills:_____
- ❑ 290 mcg PO daily — QTY:_____ Refills:_____

❑ **Trulance®**
- ❑ 3 mg PO daily with or without food — QTY:_____ Refills:_____

❑ **Viberzi®**
- ❑ 75 mg PO BID — QTY:_____ Refills:_____
- ❑ 100 mg PO BID — QTY:_____ Refills:_____

❑ **Xifaxin® 200 mg tablet**
- ❑ 200 mg PO TID for 3 days — QTY: 9 Refills:_____

❑ **Xifaxin 550 mg tablet** **If recurrence occurs then patient can be retreated up to 2 times with the same regimen.*
- ❑ 550 mg PO TID for 14 days — QTY: 42 Refills:_____
- ❑ 550 mg PO BID — QTY:_____ Refills:_____

❑ **Zinplava®**
- ❑ 10 mg/kg IV as a single dose during antibacterial treatment — 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 Palmetto Specialty Pharm, this prescription shall be forwarded to an eligible pharmacy.

Rev: 3.14.19