aleracare
advanced specialty pharmacy

Gastrointestinal Disorders (Constipation/Diarrhea)

Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Client Considerations

Diagnosis (ICD 10):

- ◯ K59.00 Constipation, unspecified
- ◯ K59.01 Slow transit constipation
- ◯ K59.02 Outlet dysfunction constipation
- ◯ K59.09 Other constipation

Other (please specify): _____

Diagnosis (ICD 10):

- ◯ K58.0 Irritable bowel syndrome with diarrhea
- ◯ K58.9 Irritable bowel syndrome without diarrhea
- ◯ K59.1 Functional diarrhea
- ◯ P78.3 Noninfective neonatal diarrhea
- R19.7 Diarrhea, unspecified

Other (please specify): _____

Medication	Dose	Directions for Use	Qty	Refills
◯ **AMITIZA®** (Lubiprostone)	◯ 8mg by mouth twice daily with food and water. ◯ 24mg by mouth twice daily with food and water.			
◯ **LINZESS®** (Linaclotide)	◯ 145mcg by mouth once daily on empty stomach 30 minutes prior to first meal of the day. ◯ 290mcg by mouth once daily on empty stomach 30 minutes prior to first meal of the day.			
◯ **RELISTOR®** (Methylnaltrexone)	◯ 3x150mg tablets once daily with water on an empty stomach at least 30 minutes before the first meal of the day. [*NB. 1 Tablet Daily with Renal/Hepatic Impairment*] ◯ 12mg pre-filled syringe SC once daily. ◯ 8mg pre-filled syringe SC every other day as needed. ◯ 12mg pre-filled syringe SC every other day as needed.			
◯ **DIFICID®** (Fidoxamicin)	◯ 200mg	◯ One tablet by mouth twice daily for 10 days.		

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature _____ **Date** _____