**Gastrointestinal Disorders (Constipation/Diarrhea)**

**REFERRAL FORM**

**Phone: 818-390-9696 Toll-free: 855-265-7850 ● Fax: 818-804-3492 Toll-free fax: 855-450-6717 ● info@MedicoRX.com**

| Patient information | | Prescriber information | |
|---|---|---|---|
| **Name:** | **DOB:** | **Prescriber's Name:** | |
| **Address:**<br>**City, State, Zip** | | **NPI#** | |
| | | **DEA#** | **License#** |
| **Phone #** | **Alt#** | **Address**<br>**City, State, Zip** | |
| **SSN:** | | | |
| **Height:** | **Wt:** | **Phone #** | **Fax #** |
| **Allergies:** | | | |
| **Emergency Contact/ Phone #** | | **Contact Person:** | |

| Clinical Consideration | |
|---|---|
| **Diagnosis (ICD 10) :** | **Diagnosis (ICD 10) :** |
| □ K59.00 Constipation, unspecified<br>□ K59.01 Slow transit constipation<br>□ K59.02 Outlet dysfunction constipation<br>□ K59.09 Other constipation | □ K58.0 Irritable bowel syndrome with diarrhea<br>□ K58.9 Irritable bowel syndrome without diarrhea<br>□ K59.1 Functional diarrhea<br>□ P78.3 Noninfective neonatal diarrhea<br>□ R19.7 Diarrhea, unspecified |
| Other (please specify)_____ | Other (please specify)_____ |

| Medication | Dose/Strength | Directions for Use | Quantity | Refills |
|---|---|---|---|---|
| □ **Amitiza®** (Lubiprostone) | □ **8 mg by mouth twice daily with food and water.**<br>□ **24 mg by mouth twice daily with food and water.** | | | |
| □ **LInzess®** (Linaclotide) | □ **145 mcg by mouth once daily on empty stomach 30 minutes prior to first meal of the day.**<br>□ **290 mcg by mouth once daily on empty stomach 30 minutes prior to first meal of the day.** | | | |
| □ **Relistor®** (Methylnaltrexone) | □ **3 X 150 mg 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}**<br>□ **12 mg pre-filled syringe SC once daily.**<br>□ **8 mg pre-filled syringe SC every other day as needed.**<br>□ **12 mg pre-filled syringe SC every other day as needed.** | | | |
| □ **Dificid®** (Fidoxamicin) | □ **200 mg** | **One tablet by mouth twice daily for 10 days.** | | |

By signing this form I authorize MedicoRX 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.

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**Prescriber's signature** (no stamps) if brand required check this ☐ DAW___ **Date**