# Bell Pharmacy

Irritable Bowel Syndrome Enrollment Form

1907 State Route 27, Edison, NJ 08817 | www.bellpharmacy.net | Email: contact@bellpharmacy.net | Phone: 732-985-1211 | Fax: 732-985-3609

## PATIENT INFORMATION

| | | |
|---|---|---|
| Name: | Date of Birth: | O Male O Female |
| Address: | City: State: | Zip: |
| Phone: | Alt Phone: | Email: |
| SS #: | Primary Language: | Emergency Contact: |

## PRESCRIBER INFORMATION

| | | | | |
|---|---|---|---|---|
| Prescribing Practitioner: | | | | NPI#: |
| Supervising Physician: | | | | NPI#: |
| Address: | City: | State: | Zip: | Tax ID: |
| Phone: | Fax: | | | Office Contact: |

## MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

O A04.7 Enterocolitis due to Clostridium difficile

O Other: _____

Is patient new to therapy: O Yes O No

Date of Diagnosis: _____

History of therapies tried/failed:

O Oral Vancomycin

O Other: _____

Immunization History

O Influenza

Date: _____

Weight: _____ lb/kg

Height: _____ in/cm

| PREVIOUS THERAPIES | Strength and Dose | Date of Therapy | Reason for Discontinuing |
|---|---|---|---|
| O _____ | O _____ | _____ | _____ |
| O _____ | O _____ | _____ | _____ |
| O _____ | O _____ | _____ | _____ |

## PRESCRIPTION INFORMATION

Needs by Date: Ship to: O Patients home O Prescriber 1st order only O Prescriber all orders O Other

| Drug | Dose | Direction | Quantity | Refills |
|---|---|---|---|---|
| O Dificid® (fidaxomicin) | O 200mg tablet | O Take one tablet by mouth twice daily for 10 days<br>O Other: _____ | O 20 | |
| O Xifaxan® (rifaximin) | O Traveler's Diarrhea | O One 200mg tablet 3 times a day for 3 days | O 9 | |
| | O Hepatic Encephalopathy | O One 550mg tablet two times daily | O _____ (K72.9) | |
| | O Irritable Bowel Syndrome w/ Diarrhea (IBS-D) | O One 550mg tablet 3 times daily for 14 days<br>O One 550mg tablet twice daily for recurrence | O 42 (K58.0)<br>O _____ | |

## INJECTION TRAINING

O Patient has received pen and injection training O Physician's office to provide injection training O Parkway Pharmacy to coordinate injection training

## PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Parkway Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner: Date

## CONFIDENTIALITY NOTICE



Faxed Prescriptions will only be accepted from a prescribing practitioner.