GASTROENTEROLOGY ENROLLMENT FORM

EMAIL: INFO@BRIGENT.COM
FAX: 818-963-7526
PHONE: 818-963-7525

IVI Pharmacy, Inc. dba
Brigent Specialty Pharmacy
4766 Park Granada Suite 112,
Calabasas, CA 91302
NPI: 1588300545

BRIGENT SPECIALTY PHARMACY

Ship to: ☐ Patient ☐ Physician ☐ Other

PATIENT INFORMATION

Patient Name (Last, First): _____ DOB: _____ Gender: ☐Female ☐Male SSN: _____
Address: _____City/State/Zip:_____
Allergies: _____ Phone: _____Alt Phone: _____
Email: _____Preferred Contact: ☐Phone ☐ Email
Parent/Caregiver/Legal Guardian Name (Last, First): _____ Phone: _____
Relationship to Patient: _____

INSURANCE INFORMATION: Please fax copy of prescription and insurance cards with this form (front and back)

CLINICAL INFORMATION

Diagnosis (ICD-10): Date of Dx: _____
☐ K76.82 Hepatic Encephalopathy ☐ A09 Traveler's Diarrhea
☐ K58 Irritable bowel syndrome ☐ K58.0 IBS w/Diarrhea
☐ K58.1 IBS w/Constipation ☐ K59.04 Chronic Idiopathic Constipation
☐ K20.0 Eosinophilic Esophagitis
☐ Other Code: _____ Description: _____

Weight:_____ lb/kg Height:_____ in/cm
TB Result: _____ Date: _____
Treatment status: ☐ New to therapy ☐ Continuation of therapy
Date of last treatment _____ Needs by: _____
Tried and Failed History: Medication: _____ Duration: _____
Response: ☐ Intolerant ☐ Ineffective ☐ Contraindicated ☐ Side Effects ☐ Other: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
☐ Amitiza	☐ 8mcg ☐ 24mcg	**Chronic Idiopathic Constipation** ☐ Take 24mcg capsule by mouth twice a day w/food and water **Irritable Bowel Syndrome w/Constipation in women aged ≥18 years** ☐ Take 8mcg capsule by mouth twice a day w/food and water	60 60	___ ___
☐ IBSRELA	☐ 50mg	☐ Take 1 tablet by mouth twice daily immediately before meals	60	___
☐ Linzess	☐ 145mcg ☐ 290mcg	**Irritable Bowel Syndrome w/Constipation (IBS-C) in adult** ☐ Take 290mcg capsule PO daily on an empty stomach at least 30 mins prior to a meal **Chronic Idiopathic Constipation** ☐ Take 145mcg capsule PO daily on an empty stomach at least 30 mins prior to a meal	30 30	___ ___
☐ Xifaxan	☐ 200mg ☐ 550mg	☐ **Traveler's Diarrhea:** Take 200mg by mouth three times a day x3 days	9	None
		☐ **Hepatic Encephalopathy:** Take 550mg by mouth twice a day	60	_____
		☐ **IBS w/Diarrhea:** Take 550mg by mouth three times a day x14 days	42	None
☐ Other	☐ _____	☐ _____	____	____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____
Address: _____ City: _____Zip: _____ Phone: _____ Fax: _____Contact Person: _____ Contact Phone: _____

PRESCRIBER SIGNATURE (DO NOT STAMP)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute
Prescriber's Signature: _____
Date: _____

May Substitute / Product Selection Permitted / Substitution Permissible
Prescriber's Signature: _____
Date: _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Brigent Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA requests as my signature.