GASTROENTEROLOGY REFERRAL FORM

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Beneva SPECIALTY PHARMACY

Ship to: ☐ Patient ☐ Prescriber ☐ Other _____

PATIENT INFORMATION

Patient Name (Last, First): _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
SSN: _____ Allergies: _____ ☐ NKDA
Phone: _____ Alternate Phone: _____
Email: _____ Preferred Contact: ☐ Phone ☐ Email
Emergency Contact: _____
Relationship to Patient: _____ Phone: _____

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

CLINICAL INFORMATION

Diagnosis (ICD-10): Date of Diagnosis: _____

☐ K76.82 Hepatic Encephalopathy ☐ A09 Traveler's Diarrhea ☐ K20.0 Eosinophilic Esophagitis ☐ K59.04 Chronic Idiopathic Constipation
☐ K58 Irritable Bowel Syndrome ☐ K58.0 IBS w/Diarrhea ☐ K58.1 IBS w/Constipation ☐ Other: _____

Treatment Status: ☐ New to Therapy ☐ Continuation of Therapy **Date of Last Treatment:** _____ **Needs By:** _____

Weight: _____ lb/kg **Height:** _____ in/cm **TB Result:** _____ **Date:** _____

Therapy Tried and Failed (please list medication and duration): _____
Response: ☐ Intolerant ☐ Ineffective ☐ Contraindicated ☐ Side effects ☐ Other: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QTY	REFILLS
☐ **Amitiza**	☐ 8 mcg ☐ 24 mcg	**Chronic Idiopathic Constipation** ☐ Take 24 mcg capsule by mouth twice a day with food and water **Irritable Bowel Syndrome w/Constipation in Women Aged ≥ 18 years** ☐ Take 8 mcg capsule by mouth twice a day with food and water	60 60	_____ _____
☐ **Ibsrela**	☐ 50 mg	☐ Take 1 tablet by mouth twice a day immediately before meals	60	_____
☐ **Linzess**	☐ 145 mcg ☐ 290 mcg	**Irritable Bowel Syndrome w/Constipation (IBS-C) in Adults** ☐ Take 290 mcg capsule by mouth daily on an empty stomach at least 30 minutes prior to a meal **Chronic Idiopathic Constipation** ☐ Take 145 mcg capsule by mouth daily on an empty stomach at least 30 minutes prior to a meal	30 30	_____ _____
☐ **Xifaxan**	☐ 200 mg ☐ 550 mg	☐ **Traveler's Diarrhea:** Take 200 mg by mouth three times a day x3days	9	None
		☐ **Hepatic Encephalopathy:** Take 550 mg by mouth twice a day	60	_____
		☐ **IBS w/Diarrhea:** Take 550 mg by mouth three times a day x14days	42	None
☐ Other (drug and strength): _____		_____	_____	_____

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

PRESCRIBER SIGNATURE (DO NOT STAMP)

"Dispense as Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May No 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 Beneva 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.

Updated 08/12/2026