

Rose Pharmacy
10008 Pines Blvd
Pembroke Pines, FL 33024
Phone: 888.797.4632 / 954.432.8290
Fax: 844.246.3364



**Irritable Bowel Syndrome
Chronic Idiopathic Constipation
Overt Hepatic Encephalopathy**

Today's Date: _____

Date Medication Needed: _____

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Insurance: _____ Policy #: _____ *Please include copy of insurance card*

Medical Criteria

Diagnosis/ICD-10 Code: _____ Height / Weight / Allergies: _____

Rx Prescription: (Circle appropriate diagnosis that applies)

☐ **Xifaxan 550mg** Dx: IBS-D/OHE ICD 10 Code: IBS-D-K58.50/OHE-K76.82

SIG: Take _____ Tablet _____ times a day

XIFAXAN can be taken with or without food

Qty: _____ Refills: _____

Condition

- HE/OHE 550mg ONE TABLET BID #60 TABLETS
- IBS-D 550mg TID for 14 days. #42 TABLETS

(Patients who experience recurrence of IBS-D can be retreated up to 2 additional times with the same regimen.)

☐ **Trulance 3mg** Dx: IBC-C/CIC ICD 10 Code: IBS-C-K58.1/CIC-K59.04

SIG: Take one Tablet orally daily

TRULANCE can be taken with or without food

Qty: _____ Refills: _____

Condition

- CIC One 3mg tablet daily
- IBS-C One 3mg tablet daily

MD Name (Printed): _____ NPI: _____ DEA: _____

Phone: _____ Fax: _____ Contact: _____

Address: _____ City: _____ State: _____ Zip: _____

MD Signature: _____ Date: _____

Contact us with questions at: info@rosenursing.net
or call **887.797.4632 / 954.432.8290**

Fax completed form and all documentation to **844.246.3364**

All information contained in this form is strictly confidential and will become part of the patient's medical record.