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

ROSE PHARMACY

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 Qty:_____ Refills:_____
TRULANCE can be taken with or without food
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 **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.