

**Patient Information – Please attach a copy of the patient’s insurance card**

Patient Name:		Date of Birth:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:		City:		State:	Zip:
Phone Number:		Alternate Phone Number:		Language:	
<b>Allergies (Required):</b>		<input type="checkbox"/> NKDA	Height:	Weight:	SSN:
<b>Product Shipping Options:</b> <input type="checkbox"/> Patient’s Home <input type="checkbox"/> Prescriber Office <input type="checkbox"/> Alternative Address:					

<b>Prescriber Information</b>					
Practice Name:			Office Contact:		
Prescriber :			NPI:		DEA:
Practice Address:		City:		State:	Zip:
Phone Number:		Fax Number:			

<b>Clinical Information – Please send all available chart notes including lab results</b>					
Diagnosis/ICD-10 : <input type="checkbox"/> Z12.11 encounter for screening malignant neoplasm of colon <input type="checkbox"/> Z8.0 family history of malignant neoplasm of digestive organs <input type="checkbox"/> Z86.010 Personal history of colonic Polyps <input type="checkbox"/> Other:					
Date of Procedure:					
Prior Failed Medications:					

<b>Prescription Information</b>		
Medication	Directions	Refills
<input type="checkbox"/> Plenvu®	Mix dose 1 with 16oz of water; thoroughly mix and then drink over the next 30 minutes. Refill the mixing container with at least 16oz of clear liquids and drink over the next 30 minutes. Repeat with second dose 12 hours after dose 1. Or as directed by physician.	
<input type="checkbox"/> Clenpiq®	Drink 1 full bottle the evening prior to colonoscopy then drink 5 cups of clear liquid. Drink the 2nd full bottle the morning of colonoscopy then drink 3 cups of clear liquid.	
<input type="checkbox"/> Other		

<b>If not covered, switch to:</b>		
Suprep	GoLYTELY	<input type="checkbox"/> MoviPrep®
Peg 3350 electrolytes	GaviLyte-C	

**PRESCRIBER SIGNATURE (PLEASE SIGN AND DATE BELOW)**

**\*Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, the receipt and submission of patient lab values and other patient data including pursuing available copay and financial assistance on behalf of my patients. If this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient’s choice or in the patient’s insurer’s provider network.

Generic substitution permitted      Therapeutic substitution permitted       Dispense as Written

**Prescriber Signature:** \_\_\_\_\_  
Date

**CONFIDENTIALITY NOTICE:** This form and its contents may contain private and confidential information that is intended for the individual or entity to which it is addressed. Any transmission of this form may contain information that is exempt from disclosure under laws including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). Unless explicitly stated, you are strictly prohibited from disseminating, copying or distributing any material contained within. Violators will be prosecuted to the fullest extent of the law. If you received this communication in error, please notify us immediately and destroy this form and its contents.