COLONOSCOPY PREP

Toll free phone: 844.749.6628
Toll free fax: 855.516.3880

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

Patient Name:		Date of Birth:	☐ Male ☐ Female
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:	Language:	
Allergies (Required):	☐ NKDA	Height:	Weight:	SSN:
Product Shipping Options: ☐ Patient's Home ☐ Prescriber O˜ice ☐ Alternative Address:			

Prescriber Information

Practice Name:		O˜ice Contact:	
Prescriber :		NPI:	DEA:
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information – *Please send all available chart notes including lab results*

Diagnosis/ICD-10 :
- ☐ Z12.11 encounter for screening malignant neoplasm of colon
- ☐ Z8.0 family history of malignant neoplasm of digestive organs
- ☐ Z86.010 Personal history of colonic Polyps
- ☐ Other:

Date of Procedure:

Prior Failed Medications:

Prescription Information

Medication	Directions	Refills
☐ 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 next30 minutes. Repeat with second dose 12 hours after dose 1. Or as directed by physician.	
☐ 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.	
☐ Other		

If not covered, switch to:

☐ Suprep ☐ GoLYTELY ☐ 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 susbstitution permitted ☐ Dispense as Written

Prescriber Signature: _____ Date