Prescription Referral Form

RELiZORB should only be used in conjunction with an enteral feeding system that has a low-flow/no-flow alarm (pump rate should be set between 24-120 mL/hour). RELiZORB should not be used with formulas that contain insoluble fiber. For more information regarding RELiZORB use, visit: www.relizorb.com, or call 1-844-RELiZORB (1-844-735-4967).

Please complete this form and email or fax to RelizorbOrder@optioncare.com or 1-844-890-1900

Patient Information

First Name: MI: Last Name:

DOB: Gender: ☐ Male ☐ Female

Address 1: Address 2:

City: State: Zip:

Preferred Phone: Authorized Contact: Phone:

Primary Diagnosis

☐ ICD-9: ☐ ICD-10: Description:

Insurance Information (Provide copies of insurance cards, front and back, if available)

Primary Insurance:

Policy ID #:

Please provide a copy of the front and back of insurance card

Enteral/DME Provider Information

Enteral/DME Provider: Phone: Fax:

Pharmacy Provider Information

Pharmacy: Phone: Fax:

Pharmacy Benefit Information

Registered Dietitian Provider Information

Email Address:

Clinical Background and Orders

1

Height: ☐ in ☐ cm Weight: ☐ lb ☐ kg Date:

Allergies: ☐ NKDA OR (list):

Please attach the following: patient demographics, insurance information, history and physical, and medication list

2

Current Enteral Formula:

Product:

Volume (mL/day): Pump Type:

Rate (mL/hour):

3

RELiZORB PRESCRIPTION: (check all that apply)

Instructions: Use 1 cartridge in-line with enteral feeding tube set, change cartridge with every 500 mL of enteral formula (Max of 2 cartridges used/day)

☐ 1 cartridge/day (500 mL) ☐ 2 cartridge/day (1000 mL) No. of Refills:

4

Additional Orders/Comments:

☐ I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: Date:

Physician Name:

NPI: UPIN:

Address: City: State: Zip:

Phone: Fax:

Office Contact: Direct Contact Number/Extension:

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. IMPORTANT WARNING: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.

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