☐ NEW START ☐ CONTINUING/RESTART TREATMENT

# Patient Enrollment

RELiZORB® (iMMOBILIZED LIPASE) CARTRIDGE

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 1-844-632-9271.

**Please complete this form and email to info@relizorbsupport.com or fax to 1-844-233-3146.**
**Please note—ALL INFORMATION IS REQUIRED to expedite processing of referral.**

## 1. Patient Information

Name (First): _____ (Last): _____

Street Address: _____ City: _____ State: _____ ZIP: _____

SSN #: _____ Date of Birth: _____ Age: _____ Gender: ■ Male ☐ Female

**Patient/Patient Representative Contact Information:**

Primary Phone: _____ Patient Representative Name: _____

Secondary Phone: _____ Patient Representative Relationship:: _____

Email: _____

## 2. Current Insurance Information

**Primary Insurance Plan:** ☐ Private/Commercial ☐ Medicaid ☐ Medicare ☐ Medicare Advantage ☐ Patient has no insurance

Primary Insurance Name: _____

Insurance Phone #: _____ Member ID #: _____

Policy Holder: _____ Policy Holder Date of Birth: _____ Relationship to Patient: _____

**Secondary Insurance Plan:** ☐ Private/Commercial ☐ Medicaid ☐ Medicare ☐ Medicare Advantage ☐ Patient has no insurance

Secondary Insurance Name: _____

Insurance Phone #: _____ Member ID #: _____

Policy Holder: _____ Policy Holder Date of Birth: _____ Relationship to Patient: _____

**NOTE: Please attach a copy of the insurance card (front and back)**

## 3. Prescriber Information

Prescriber Name (First): _____ (Last): _____

NPI: _____ PTAN: _____

Tax ID #: _____ DEA: _____

Prescriber Specialty: _____

Center/Hospital Name: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Prescriber Direct Contact #: _____

Best day(s)/times if peer-to-peer is needed: _____

Primary Office Contact: _____ Phone: _____ Ext: _____

Email: _____ Fax: _____

## 4. Prescription for RELiZORB® (iMMOBILIZED LIPASE) CARTRIDGE

**In order for us to send RELiZORB to your patient, the prescription information must be complete and accurate.**

Patient Name (First, Last): _____ Date of Birth: _____

Primary Diagnosis Code: _____

Secondary Diagnosis Code: _____

Other Diagnosis Code(s): _____

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

Current Enteral Formula: _____ Tube Placement Date: _____

Volume (mL/day): _____ Pump Type: _____ Rate (mL/hour): _____

**Product Name: RELiZORB® (iMMOBILIZED LIPASE) CARTRIDGE** (NDC 62205-0000-20)

**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)
Dispense 30 each/cartridge

☐ 2 cartridges/day (1000 mL)
Dispense 60 each/cartridge

☐ No. of refills: _____

**Additional Orders/Comments:** _____

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

**Doctor/Prescriber Signature** ❯ _____ **Date:** _____

## 5. Continuity of Care/Hospital Discharge

RELiZORB is committed to your patient's continuity of care on the journey to home.

☐ Please check this box for hospital discharge patients

## 6. Clinical Indications Supporting Medical Necessity: (Please check all that apply)

☐ Patient has failed to achieve enteral feeding goals with pancreatic enzyme replacement therapy in conjunction with enteral feeding.

☐ Patient exhibits symptoms of fat malabsorption including but not limited to:

☐ Diarrhea ☐ Fatty stools ☐ Abdominal pain ☐ Bloating

☐ Nausea ☐ Constipation ☐ Flatulence ☐ Vomiting

☐ Patient demonstrates failure to achieve or maintain target BMI.

☐ Patient requires overnight enteral feeding to meet caloric and nutritional demands with need for sustained lipase delivery throughout feed.

☐ Patient exhibits deficiency in fatty acid levels.

☐ Patient's symptoms of fat malabsorption impair or inhibit patient's activites of daily living and quality of life.

**Doctor/Prescriber Signature** ❯ _____ **Date:** _____

## 7. Please Include the Following Clinical Documentation:

☐ **Copy of front and back of insurance card**
☐ **MD office visit notes including initial evaluation/H&P, referrals**
☐ **RD office notes**
☐ **Medication list**
☐ **Weight history**
☐ **Letter of medical necessity, if needed**

ALCRESTA® THERAPEUTICS