☐ NEW START ☐ CONTINUING/RESTART TREATMENT

RELiZORB®
(iMMOBILIZED LIPASE) CARTRIDGE

Patient Enrollment

RELiZORB should only be used in conjunction with enteral feeding supplies. RELiZORB should not be used with blenderized formulas. 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:

Patient Representative Name: ______________________________ Phone Number: ______________________________

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): ______________________________ ☐ MD ☐ DO ☐ NP ☐ PA

NPI: ______________________________ PTAN: ______________________________

Tax ID #: ______________________________ DEA: ______________________________

Prescriber Specialty: ______________________________

Center/Hospital Name: ______________________________

Street Address: ______________________________ City: ____________________ State: __________ ZIP: __________

Prescriber Direct Contact #: ______________________________

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: ______________________

Pump Type (if applicable): ______________________

Product Name: RELiZORB® (iMMOBILIZED LIPASE) CARTRIDGE (NDC 62205-0000-20, third party-derived NDC based on UDI number, for reimbursement purposes)

RELiZORB PRESCRIPTION (complete table)
Instructions: Use 1 cartridge for tube feeding with an enteral pump with every 500 mL of formula, or use 1 cartridge for bolus feeding with enteral syringe with up to 250 mL of formula.

Feeding Mode	Formula Volume (mL/day)	Flow rate (if applicable)	Number of cartridges/day	Number of refills (#)
☐ Continuous via Pump ☐ Bolus via Pump or Syringe			☐ 1 cartridge/day (dispense 30ea) ☐ 2 cartridges/day (dispense 60ea) ☐ 3 cartridges/day (dispense 90ea) ☐ 4 cartridges/day (dispense 120ea) ☐ 5 cartridges/day (dispense 150ea) ☐ 6 cartridges/day (dispense 180ea)	

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

Outpatient Provider Name ______________________

Phone Number ______________________ Expected Discharge Date ______________________

6. Please Include the Following Clinical Documentation to help expedite processing of referral:

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

Please remember to have your patient complete the Patient Authorization form.
This form can be found online at www.relizorb.com/authorization.

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