SOLESTA® (dextranomer and sodium hyaluronate)

PATIENT INFORMATION

Patient Name:		SSN:		DOB:
Address:		City:	State:	Zip:
Home Phone:	Cell Phone:	Height:	Weight:	Gender: ◯ Male ◯ Female
Email Address:		Diagnosis Code:		

INSURANCE INFORMATON (or attach copy of the cards)

Primary Insurance Co:	Policy Holder:	Relationship:	Policy #:	Group #:
Secondary Insurance	Policy Holder:	Relationship:	Policy #:	Group #:
Pharmacy Benefits	Policy Holder:	Relationship:	Policy #:	Group #:

PRESCRIPTION INFORMATION

SOLESTA® *(dextranomer and sodium hyaluronate) 1 ml* Prefilled Syringe

☐ 4 submucosal injections

Qty: 4 **Refills:**

SOLESTA® is indicated for the treatment of fecal incontinence in patients 18 years and older who have failed conservative therapy (e.g. diet, fiber therapy, anti-motility medications).

ManifestRx

Fax Order to: 1-864-663-5285

Full Benefit Verification

Phone: 888-770-4009

Available: 8am - 5pm ET Monday -Friday

Patient Complete Benefits will be investigated and processed UNLESS indicated below

☐ Verify Only: Medical and Pharmacy Benefits (Physician Office is a Buy and Bill Practice)

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution.	Surgical Date

PHYSICIAN INFORMATION : The address below also represents Solesta Ship To Location

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:		
NPI #:	Tax ID#:	
Prescription Signature:		Date:

Your signature authorizes ManifestRX, 1018 S. Batesville Road, Greer, SC 29650o act on your behalf to obtain prior authorization for the prescribed medications. We will also pursue available copay and financial assistance on behalf of your patients.

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