Solesta®

Patient Enrollment Form

DEVICE NAME: **Solesta®** (dextranomer and sodium hyaluronate) ☐ Office ☐ ASC ☐ HOPD

PATIENT INFORMATION

Patient Name _____ SSN _____ DOB _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Diagnosis Code _____ Height _____ Weight _____ Gender ☐ Male ☐ Female

INSURANCE INFORMATION (and attach copy of the cards) - DEMOGRAPHIC SHEET (also accepted)

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) 1ml Prefilled Syringe

☐ 4 submucosal injections QTY: 4 units 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

Provider Support Line

Medical/Pharmacy Benefit Team DIRECT PHONE: 888-333-4884

Solesta Market Access Team DIRECT PHONE: 855-430-9430

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 the Barrigel ship to location)

Provider Name _____ Phone _____ Fax _____

Office Contact _____ Email _____

Address _____

NPI # _____ Tax ID # _____

Provider Signature: _____ Date _____