AcariaHealth
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Prescriber
☐ Nursing needed; ☐ Training needed ▶ All the supplies including syringes and needles will be dispensed if needed.

XIFAXAN REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ☐ M ☐ F ☐ Other:	Weight:	☐ lbs. ☐ kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	☐ **Additional Information Attached**		

PRESCRIBER INFORMATION

Prescriber:		NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:		Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

Primary Diagnosis: ☐ K58.0 Irritable Bowel Syndrome with Diarrhea ☐ K72.91 Hepatic Encephalopathy ☐ A09 Traveler's Diarrhea due to E. coli ☐ Other:_____

- Has patient been treated previously for this condition? ☐ Yes ☐ No *** Please indicate all prior treatments tried and failed ***

Irritable Bowel Syndrome with Diarrhea	Dates (Start / End)	Hepatic Encephalopathy	Dates (Start / End)
☐ Antispasmodic:		☐ Ciprofloxacin	
☐ Dicyclomine (Bentyl)		☐ Lactulose	
☐ Hyosyamine (Levsin)		☐ Metronidazole	
☐ Cimetropium		☐ Neomycin	
☐ Diphenoxylate/Atropine (Lomotil)		☐ Other:	
☐ Loperaminde (Imodium)			
☐ Lotronex (Alosetron)			
☐ Tricyclic Antidepressants			
☐ Amitriptyline			
☐ Other:			
☐ OTC Medications			
☐ Fiber Supplements			
☐ Anti-diarrheal			

- Is patient *currently* on therapy? ☐ Yes ☐ No Medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ☐ Yes ☐ No If yes:_____
- How long should patient wait before starting the new medication? _____
- Other medication(s) patient is currently taking including OTC medications with dosage and direction (or fax medication profile):_____
- Patient's medical history includes: ☐ Severe-hepatic impairment ☐ Current pregnancy ☐ Other:_____

INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

☐ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

☐ **Xifaxan® 550 mg Tablet**
- ☐ Irritable Bowel Syndrome with Diarrhea: 1 tablet PO three times daily for 14 days **If recurrence occurs then patient can be retreated with the same regimen* QTY: 42 Tablets | Refills:
- ☐ Hepatic Encephalopathy: 1 tablet PO two times a day QTY: | Refills:

☐ **Xifaxan® 200 mg Tablet**
- ☐ Traveler's diarrhea due to E. coli: 1 tablet PO three times daily for 3 days QTY: 9 Tablets | Refills:

☐ **Other:** _____ QTY: | Refills:

I authorize AcariaHealth to enroll me in a manufacturer-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to: injection training. I further authorize the release to the corresponding manufacturer the minimum necessary information about my health condition and prescriptions to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis, and provide educational information regarding therapies. I understand that I may revoke this authorization at any time in writing by sending a letter to AcariaHealth 6923 Lee Vista Blvd., Suite 300, Orlando, FL 32822. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. A copy of this authorization will be utilized with the same effectiveness as the original.

Patient Signature: _____ Date: _____

Prescriber's Signature: _____ ☐ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.