

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)
<input type="checkbox"/> Antispasmodic:		<input type="checkbox"/> Ciprofloxacin	
<input type="checkbox"/> Dicyclomine (Bentyl)		<input type="checkbox"/> Lactulose	
<input type="checkbox"/> Hyosyamine (Levsin)		<input type="checkbox"/> Metronidazole	
<input type="checkbox"/> Cimetropium		<input type="checkbox"/> Neomycin	
<input type="checkbox"/> Diphenoxylate / Atropine (Lomotil)		<input type="checkbox"/> Other:	
<input type="checkbox"/> Loperamide (Imodium)			
<input type="checkbox"/> Lotronex (Alosetron)			
<input type="checkbox"/> Tricyclic Antidepressants			
<input type="checkbox"/> Amitriptyline			
<input type="checkbox"/> Other:			
<input type="checkbox"/> OTC Medications			
<input type="checkbox"/> Fiber Supplements			
<input type="checkbox"/> 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.**

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to AcariaHealth or any of its subsidiaries using the contact information provided on this coversheet.