

Phone: 888.868.3605 • Fax: 888.837.7837

DIFICID REFERRAL FORM

PATIENT INFORMATION			
Patient Name:	DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg.
SSN:	Phone:	Allergies:	
Address:	City:	State:	Zip:
Emergency Contact:	Phone:	<input type="checkbox"/> Please attach demographic information	
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: (ICD-10 Code & Description) _____			
<ul style="list-style-type: none"> ▪ Has patient been treated <i>previously</i> for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____ ▪ Is patient <i>currently</i> on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s): _____ ▪ Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____ ▪ How long should patient wait before starting the new medication? _____ ▪ Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____ 			
INSURANCE INFORMATION			
<input type="checkbox"/> Please attach front and back of patient's insurance card (medical and prescription)			
COPAY CARD ENROLLMENT			
<input type="checkbox"/> Please check if enrolling in copay card		Copay ID: _____	
PRESCRIPTION INFORMATION			
<input type="checkbox"/> Dificid 200 mg tablet			
<input type="checkbox"/> Take one tablet by mouth twice daily for 10 days with or without food		QTY: <u>20</u>	Refills: _____
<input type="checkbox"/> Alternate dose: _____		QTY: _____	Refills: _____

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 prescription 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.