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

XIFAXIN REFERRAL FORM

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ **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 ASSESMENT

Primary Diagnosis: ❑K58.0 Irritable Bowel Syndrome with Diarrhea ❑K72.91 Hepatic Encephalopathy ❑A09 Travelers' 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: ❑Dicyclomine (Bentyl) ❑Hyosyamine (Levsin) ❑Cimetropium ❑Diphenoxylate/atropine (Lomotil) ❑Loperaminde (Imodium) ❑Lotronex (Alosetron) ❑Tricyclic antidepressants ❑Amitriptyline ❑Other: _____ ❑OTC medications ❑Fiber supplements ❑Antidiarrheal		❑Ciprofloxacin ❑Lactulose ❑Metronidazole ❑Neomycin ❑Other: _____	

- 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 medications 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

❑Xifaxin® 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:____

❑Xifaxin® 200 mg tablet

❑Travler's diarrhea due to E.coli: 1 tablet PO three times daily for 3 days QTY: 9 tablets Refills:____

❑Other: _____ QTY: _____ Refills:____

I authorize the dispensing pharmacy 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 the dispensing pharmacy. 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 prescription on official state prescription blank. In the event requested agent is not available through the receiving pharmacy, this prescription shall be forwarded to an eligible pharmacy.

3.20.19