XIFAXAN ENROLLMENT FORM

252B Port Richmond Ave, Staten Island, NY 10302

Date: ______________ Needs By Date: ________________

Ship to: ❑ Patient ❑ MD Office Language: __________

Nursing Instruction Required: ❑ Yes ❑ No

FAX REFERRAL TO: 718-360-9655
OR CALL 718-556-0942

Prescriber Information:

Prescriber: ______________________________

____

Address: ______________________________

____

Office Phone: ______________________________

Office Fax: ______________________________

NPI: ______________________________

PATIENT INFORMATION- Complete the following or send patient demographic sheet

Patient Name ____

Address ________________________________ City ____________ State _____ Zip ________

Home Phone ______________________________ Alternate Phone ____________________

Patient SS # ______________________________ Date of Birth _____ / _____ / _____ Sex ❑ M ❑ F

Height ____________ Weight ________ ❑ lbs ❑ kg Patient Allergies ______________________

Special Instructions ____

INSURANCE INFORMATION (Complete or attach copies of cards)

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFO

Primary Insurance ______________________________ Policyholder ________________

Group # ______________________________ Phone # ________________

Secondary Insurance ______________________________ Policyholder ________________

Group # ______________ Policy # ______________ Phone # ________________

PRESCRIPTION COVERAGE

BIN # __________________ ID # __________________ Group # __________________

DIAGNOSIS / MEDICAL INFORMATION

PLEASE ATTACH ALL PRIMARY AND SECONDARY INSURANCE INFO

Xifaxan® 550 mg Refills ____________

ICD-10: Hepatic Encephalophathy - K72.0 ❑ BID for 30 days

Irritable Bowel Syndrome with Diarrhea (IBS-D) - K58.0 ❑ TID for 14 days

Other ______________________________ ❑ ____________

Prior (Failed) Medications: ____

Physician's Signature ______________________________ Date ____ / ____ / ____