encore pharmacy

Xifaxan CONNECT

Xifaxan Connect Prescription Enrollment Form

DATE: _____
DATE NEEDED: _____

SHIP TO:
☐ PATIENT

PHARMACY:
PHONE: 817-335-5712
FAX: 817-332-5363
NPI: 1952401259 NCPDP: 45-09634

PATIENT INFO

NAME: _____ E-MAIL_____ DOB:_____ ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY_____ STATE_____ ZIP_____

HOME TELEPHONE:_____ MOBILE PHONE:_____ SS#__ __ __ - ___ ___ - ___ ___ ___ ___

☐ Patient demographic sheet attached

INSURANCE INFORMATION

PLEASE FAX COPY OF INSURANCE CARD (Front & Back)

DIAGNOSIS:
Date of Diagnosis_____

☐ K72.90 Hepatic failure, unspecified without coma
☐ K76.82 Hepatic Encephalopathy (HE)
☐ K58.0 Irritable Bowel Syndrome with Diarrhea
☐ Other _____

CLINICAL INFORMATION

HEPATIC ENCEPHALOPATHY

CLINICAL INFORMATION

PREVIOUS TREATMENTS TRIED AND FAILED (Check all that apply or attach list of "Tried and Failed" therapies)

TRIED & FAILED:	Date Start	Date End	TRIED & FAILED:	Date Start	Date End
☐ Lactulose			☐ Neomycin		
☐ Ciprofloxacin			☐ Other		
☐ Metronidazole					

Is the patient currently on therapy for this diagnosis? ☐ Yes ☐ No
Please list current medication(s) and treatment duration(s): _____

Will the patient be taking lactulose along with this medication? ☐ Yes ☐ No
If no, do either of the following reasons apply? ☐ Inadequate response to lactulose ☐ Intolerance or contraindication to lactulose

Other medications patient is currently taking (including prescription and OTC medications) Please fax medication profile, or list below:

_____

Medical history and comorbidities:: ☐ severe hepatic impairment ☐ Other:_____

HEPATIC ENCEPHALOPATHY PRESCRIPTION INFORMATION

PRESCRIPTION INFORMATION

Medication, Dosage Form / Strength	Directions	Quantity	Refill
☐ **Xifaxan® (rifaximin) 550mg tablet**	**For Hepatic Encephalopathy:** ☐ Take 1 tablet PO BID ☐ Other:_____	☐ 60 ☐ 180 ☐ _____	☐ _____
☐ Other:_____	☐ _____	☐ _____	☐ _____

IRRITABLE BOWEL SYNDROME WITH DIARRHEA

CLINICAL INFORMATION

PREVIOUS TREATMENTS TRIED AND FAILED (Check all that apply or attach list of "Tried and Failed" therapies)

TRIED & FAILED:	Date Start	Date End	TRIED & FAILED:	Date Start	Date End
☐ Dicyclomine (Bentyl)			☐ Antidiarrheals		
☐ Cimetropium			☐ Loperamide (Imodium)		
☐ Hyosyamine (Levsin)			☐ Alosetron (Lotronex)		
☐ Amitriptyline			☐ Diphenoxylate / Atropine (Lomotil)		
☐ Fiber Supplements			☐ Other		

IRRITABLE BOWEL PRESCRIPTION INFORMATION

PRESCRIPTION INFORMATION

Medication, Dosage Form / Strength	Directions	Quantity	Refill
☐ **Xifaxan® (rifaximin) 550mg tablet**	**For IBS-D:** ☐ Take 1 tablet PO TID ☐ Other:_____	☐ 42 ☐ _____	☐ _____
☐ Other:_____	☐ _____	☐ _____	☐ _____

Prescriber Certification of Patient Consent

Prescriber Certification of Patient Consent: By signing below, I further certify and warrant that I have fully explained to the patient the details of this Enrollment Form and the program, including that (i) the Pharmacy is a specialty pharmacy that will ship the product directly to the patient's home address and will be calling the patient on a regular basis to help ensure adherence and answer any patient questions, and (ii) the patient may opt-out of this program by providing notice to the Pharmacy at any time. I also certify that I have complied with all applicable laws regarding the patient's personal health information (PHI) and have obtained written authorization from the patient to disclose such PHI for these purposes, including all information relating to the patient's medical conditions and prescription medications disclosed in this Enrollment Form. **Date:** _____

PRESCRIBER SIGNATURE:_____

PRESCRIBER INFORMATION

Prescriber's Name: _____ Contact Person:_____

Telephone: _____ Fax:_____ Email:_____

Office Address:_____ City:_____ State: _____ Zip:_____

NPI # : _____ DEA # : _____ UPIN # : _____ Medicaid Provider # : _____

_____ _____ *_____

PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I acknowledge that the ICD-10 Codes, previous treatments, and related information are included in this Enrollment Form for informational purposes only, and that it is the treating physician's responsibility to determine the proper diagnosis, treatment and applicable ICD-10 Code. By signing above, I certify and warrant that this Enrollment Form has been prepared exclusively by me or my office, and that the above prescribing decisions are based on my own independent medical judgment regarding the best interests of the patient. I also hereby authorize the Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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