

# Xifaxan® Enrollment Form

(Please use black ink)

## PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address 2 \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_  
 DOB \_\_\_\_\_ Last Four of SS# \_\_\_\_\_ Gender \_\_\_\_\_  
 Language Preference: English Spanish Other \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber's Name \_\_\_\_\_  
 DEA \_\_\_\_\_  
 NPI \_\_\_\_\_  
 Group/Hospital \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION

Prior Authorization Reference number \_\_\_\_\_

## MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

**Diagnosis** — Please include diagnosis name with ICD-10 code

**Additional Information**

Therapy: New Reauthorization Restart

K72.91 Hepatic encephalopathy  
 K58.00 Irritable bowel syndrome  
 R19.7 Traveler's diarrhea  
 Other:  
 ICD-10 Code: \_\_\_\_\_  
 Description: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\*\*\*Please include most recent progress notes and labs.

Weight \_\_\_\_\_ kg/lbs Height \_\_\_\_\_ cm/in

Allergies \_\_\_\_\_

**Drugs tried and failed:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Additional Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions	Quantity	Refills

\* **Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution permitted  Dispense as Written

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

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