MED CENTER SPECIALTY PHARMACY

Dedicated to Improving Our Patients' Health

Part of The Elwyn Pharmacy Group

XIFAXAN® PRESCRIPTION REFERRAL FORM

3100 MacCorkle Avenue S.E. Suite 100 Charleston, WV 25304

TEL: 304-344-8021 FAX: 304-344-0655

Today's Date

☐ **NEW PATIENT** ☐ **CURRENT PATIENT**

July 2016

Patient Name First Name Middle Name Last Name DOB Weight ☐ Male ☐ Female

Street Address Apt # City State Zip

Daytime Tel Evening Tel Cell Email

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed

ICD-10 Diagnosis ☐ K72.91 Hepatic Encephalopathy ☐ Other

Allergies

Insured's Name Relation to Patient Eligible for Medicare ☐ Yes ☐ No If yes, Medicare#

Prescription Card ☐ Yes ☐ No If Yes, Carrier Tel Fax Policy/Group#

Bin# Pcn# RXID# RX Group#

Prescriber's Name Office Contact

Street Address Suite # City State Zip

Tel Fax Email

License# NPI# UPIN# DEA#

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

XIFAXAN® (RIFAXIMIN)

Dose: ☐ 550mg Tablets

Directions: Take one 550mg tablet orally two times a day

QTY: 60 Refills:

Previous Treatments Tried and Failed (Check all that apply)

Hepatic Encephalopathy

☐ Ciprofloxacin	Start Date:	End Date:
☐ Lactulose	Start Date:	End Date:
☐ Metronidazole	Start Date:	End Date:
☐ Neomycin	Start Date:	End Date:
Other:	Start Date:	End Date:
Other:	Start Date:	End Date:

OTHER

Medication:

Dose:

Directions:

QTY: Refills:

OTHER

Medication:

Dose:

Directions:

QTY: Refills:

By signing this form and utilizing our services, you are authorizing Med Center Specialty Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) **Date**

Please fax completed referral form to **Med Center Specialty Pharmacy** at **304-344-0655** Visit us at **WWW.MEDCENTERSPECIALTYPHARMACY.COM** for online fillable forms.