

MED CENTER SPECIALTY PHARMACY

A **BIOMATRIX** Company

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
Feb 2018

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** _____

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