

### XIFAXAN REFERRAL FORM

#### PATIENT INFORMATION

 Patient Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell \_\_\_\_\_  
 DOB \_\_\_\_\_ SSN \_\_\_\_\_  
 Drug Allergies \_\_\_\_\_  Male  Female  
 Patient Weight: \_\_\_\_\_ Height: \_\_\_\_\_

#### PRESCRIBER INFORMATION

 Prescriber Name \_\_\_\_\_ Lic# \_\_\_\_\_  
 DEA# \_\_\_\_\_ NPI \_\_\_\_\_  
 Practice Name \_\_\_\_\_  
 Address \_\_\_\_\_ Suite \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Office Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Office Contact \_\_\_\_\_

#### INSURANCE, MEDICARE OR MEDICAID INFORMATION

 Primary Insurance \_\_\_\_\_ Secondary Insurance (if applicable) \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group \_\_\_\_\_ Policy # \_\_\_\_\_  
 Insurance Phone \_\_\_\_\_ Insurance Phone \_\_\_\_\_  
 Prescription Drug Coverage: Company \_\_\_\_\_ Phone \_\_\_\_\_  
 RXGRP# \_\_\_\_\_ RXBIN# \_\_\_\_\_ PCN/ID# (if available) \_\_\_\_\_

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS

#### CLINICAL INFORMATION

 Primary Diagnosis:  K72 Hepatic Encephalopathy     K58.0 Irritable Bowel Syndrome with Diarrhea     A09 Travelers' Diarrhea     Other \_\_\_\_\_  
 Currently on therapy:  Yes  No \_\_\_\_\_ Date Treatment Started: \_\_\_\_\_  
 Pertinent PMH/Diagnostic Testing: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DRUG NAME	DOSE/FREQUENCY	DIRECTIONS FOR USE	QTY	REFILLS
<input type="checkbox"/> Xifaxan	550mg tablet	Take 1 tablet twice daily with or without food.	30 day supply	
<input type="checkbox"/> Xifaxan	550mg tablet	Take 1 tablet three times a day for 14 days with or without food.	14 day supply	
<input type="checkbox"/> Xifaxan	200mg tablet	Take 1 tablet three times a day for 3 days with or without food.	3 day supply	

 Deliver to:  Patient's home     Other \_\_\_\_\_

By signing this form and utilizing our services, you are authorizing Benevere 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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