benevere PHARMACY

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beneverepharmacy.com

TODAY'S DATE: ______________
☐ NEW PATIENT ☐ CURRENT PATIENT

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 ______________________________
Policy # ______________ Group ______________
Insurance Phone ______________________________
Prescription Drug Coverage: Company ______________________________

Secondary Insurance (if applicable) ______________________________
Policy # ______________________________
Insurance Phone ______________________________
Phone ______________________________

RXGRP# ______________ RXBIN# ______________ PCN/ID# *(if available)* ______________

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

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
☐ Xifaxan	550mg tablet	Take 1 tablet twice daily with or without food.	30 day supply	
☐ Xifaxan	550mg tablet	Take 1 tablet three times a day for 14 days with or without food.	14 day supply	
☐ 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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