benevere PHARMACY

60 Market Center Dr. #103, Collierville, TN 38017
O: 901.316.5752 TP: 855.344.8724 F: 901.316.5760 TF: 844.588.5560
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 _____

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

Secondary Insurance (if applicable) _____

Policy # _____

Insurance Phone _____

Phone _____

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 _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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