Xifaxan® 550 mg Enrollment Form

PRx

PATIENT INFORMATION

Patient Name: ______________________________________
Date of Birth: ____ /____ / ____ ☐ Male ☐ Female
SSN: ____ -____ - ____
Address: ____
City: _____________ State: _____ Zip: _______________

Phone: (____) - ____ - ________
Email: ____
Preferred method of contact: ☐ Phone ☐ Email
Height: ________ in Weight: ________ lb Date: ____ /____ / ____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: __________________ ID#: ________________________ Group #: ______________ RxBIN: _________ RxPCN: _________

PRESCRIBER INFORMATION

Prescriber Name: ________________________________
Address: _____________________________________
City: _____________ State: _____ Zip: _______________
Contact: ________________________
Clinic/Hospital Affiliation: ____________________________

Phone: (____) - ____ - ________
Fax: (____) - ____ - ________
License #: ________________________
NPI #: ________________________
Medicaid Provider #: ________________________

X550RX-19-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ K72.9 Hepatic failure, unspecified (Hepatic Encephalopathy)
☐ K58.0 Irritable Bowel Syndrome with Diarrhea
☐ Other: ______________

Please list previously tried/failed therapies & dates:
☐ Lactulose Date: ____ /____ / ____
☐ Metronidazole Date: ____ /____ / ____
☐ Neomycin Date: ____ /____ / ____
☐ Loperamide Date: ____ /____ / ____
☐ Cholestyramine Date: ____ /____ / ____
☐ Colestipol Date: ____ /____ / ____
☐ Dicyclomine Date: ____ /____ / ____
☐ Hyoscyamine Date: ____ /____ / ____
☐ Tricyclic Antidepressants Date: ____ /____ / ____
☐ SSRI Date: ____ /____ / ____
☐ Other therapies:

Immunization History
☐ Influenza
Date: ____ /____ / ____

Rx

Medication	Dose/Strength	Directions	Quantity	Refills
Xifaxan® (rifaximin)	☐ 550 mg tablet	☐ Take one tablet by mouth twice daily		
		☐ Take one tablet by mouth three times daily for 14 days	42	
		☐ Other:		

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: ______________________________ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____

PANTHER RARE

PHONE: 855-726-8479 (412-246-9858) **FAX**: 855-246-3986 (412-787-9400) **www.pantherxrare.com**

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