ahma (rx)

XIFAXAN

Toll free phone: 844.749.6628
Toll free fax: 888.966.0647

Patient Information – Please attach a copy of the patient's insurance card

Patient Name:		Date of Birth:	☐ Male ☐ Female
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:		Language:
Allergies (Required): ☐ NKDA	Height:	Weight:	SSN:

Product Shipping Options: ☐ Patient's Home ☐ Prescriber Office ☐ Alternative Address:

Prescriber Information

Practice Name:		Office Contact:	
Prescriber:		NPI:	DEA:
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information – *Please send all available chart notes including lab results*

Primary Diagnosis: ❑K58.0 Irritable Bowel Syndrome with Diarrhea ❑K72.91 Hepatic Encephalopathy ❑A09 Travelers' Diarrhea due to E. coli ❑Other:____________

- Has patient been treated *previously* for this condition? ❑Yes ❑No Please indicate all prior treatments tried and failed:

Irritable Bowel Syndrome with Diarrhea	Dates (Start/End)
❑Antispasmodic: ❑ Dicyclomine (Bentyl) ❑ Cimetropium ❑ Hyosyamine (Levsin)	
❑Diphenoxylate/atropine (Lomotil)	
❑Loperaminde (Imodium)	
❑Lotronex (Alosetron)	
❑Tricyclic antidepressants ❑ Amitriptyline ❑Other: ________________	
❑OTC medications ❑Fiber supplements ❑Antidiarrheal	

Hepatic Encephalopathy	Dates (Start/End)
❑Ciprofloxacin	
❑Lactulose	
❑Metronidazole	
❑Neomycin	
❑Other:______________________	

- Is patient *currently* on therapy? ❑Yes ❑ No; Please list current medication(s) and treatment duration(s):________________________________
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No
  If *yes*, how long should patient wait before starting the new medication? ________________________________
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):
  ____
- Patient's medical history includes: ❑Severe hepatic impairment ❑Current pregnancy ❑Other:________________________________

Prescription Information

❑Xifaxan® 550mg tablet

❑Irritable Bowel Syndrome with Diarrhea: 1 tablet PO three times daily for 14 days — QTY: __42__ tablets — Refills: _____
****if recurrence occurs then patient can be retreated up to 2 times with the same regimen****

❑Hepatic Encephalopathy: 1 tablet PO two times daily — QTY: ______ tablets — Refills: _____

❑Xifaxan® 200mg tablet

❑Travelers' Diarrhea due to E. coli: 1 tablet PO three times daily for 3 days — QTY: __9__ tablets — Refills: _____

❑Other: ________________________________ — QTY: ______ tablets — Refills: _____

PRESCRIBER SIGNATURE (PLEASE SIGN AND DATE BELOW)

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, the receipt and submission of patient lab values and other patient data including pursuing available copay and financial assistance on behalf of my patients. If this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product substitution permitted ☐ Dispense as Written

Prescriber Signature: ________________________________ ________________
Date

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