



Xifaxan Intake Form

E-Prescribing to AllCare Plus Pharmacy Available
 NCPDP 2243880 Toll free (855) 880-1091 Toll free fax (844) 265-0265
 50 Bearfoot Road, Northborough, MA 01532
www.AllCarePlusPharmacy.com

PATIENT INFORMATION	
Patient Name	
Address	
City, State, Zip	
Phone	
Social Security	
Date of Birth	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

PRESCRIBER INFORMATION	
Prescriber Name	
Group/Hospital	
Address	
City, State, Zip	
Phone	Fax
DEA/NPI #	
Preparer Name/Office Contact	

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Primary Diagnosis & ICD-10 Code:

- K72.91** Hepatic Encephalopathy
- K58.0** Irritable Bowel Syndrome with Diarrhea
- A09** Travelers' Diarrhea

Other ICD-10 Code: _____

Diagnosis Date: _____

ALLERGIES: _____

Additional Notes: _____

Is this patient currently on therapy? Yes No

Medication(s): _____

Other medications patient is currently taking including OTC medications with dosage and directions (or fax medication profile):

Previous Treatments:

- | | |
|---|---|
| <input type="checkbox"/> Antispasmodics
<input type="checkbox"/> Dicyclomine (Bentyl)
<input type="checkbox"/> Hyosyamine (Levsin)
<input type="checkbox"/> Cimetropium | <input type="checkbox"/> Tricyclic Antidepressants:
<input type="checkbox"/> Amitriptyline
<input type="checkbox"/> Other: _____ |
|---|---|

PRESCRIPTION INFORMATION

DRUG	DOSAGE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Xifaxan® (Rifaximin)	550 mg Tablets	Take 1 tablet twice daily with or without food.	30 day supply (60 Tablets)	_____
<input type="checkbox"/> Xifaxan® (Rifaximin)	550 mg Tablets	Take 1 tablet three times a day for 14 days with or without food.	14 day supply (42 Tablets)	_____

Physician Signature: _____ Date: _____

I authorize AllCare Plus Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should the material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. This is a patient enrollment form for the above mentioned therapies. Patients have the right to use the Pharmacy of their choice, if AllCare Plus Pharmacy is the Pharmacy of choice, please follow up with a call in, electronic, faxed or mailed prescription to AllCare Plus Pharmacy, 50 Bearfoot Road, Northborough, MA 01532. (Phone) 1 855 880 1091 (Fax) 1 844 265 0265