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 ☐ Male ☐ 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: _____

_____

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:

☐ **Antispasmodics**
- ☐ Dicyclomine (Bentyl)
- ☐ Hyosyamine (Levsin)
- ☐ Cimetropium

☐ **Trycyclic Antidepressants:**
- ☐ Amitriptyline
- ☐ Other: _____

Additional Notes: _____

_____

_____

PRESCRIPTION INFORMATION

DRUG	DOSAGE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ **Xifaxan®** (Rifaximin)	**550 mg Tablets**	**Take 1 tablet twice daily with or without food.**	**30 day supply** (60 Tablets)	_____
☐ **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.