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.

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