Xifaxan Connect Prescription Enrollment Form

DATE: ____________________
DATE NEEDED: ________________

SHIP TO: ☐ PATIENT

PHARMACY:
PHONE: 1-833-861-2343
FAX: 1-850-704-4231
NPI: 1952401259 NCPDP: 45-09634

PATIENT INFO

NAME: ________________ E-MAIL________________ DOB:____________ ☐ MALE ☐ FEMALE

ADDRESS: ________________ CITY________________ STATE________ ZIP__________

HOME TELEPHONE:________________ MOBILE PHONE:________________ SS#__ __ __ - __ __ - __ __ __ __

☐ Patient demographic sheet attached

INSURANCE INFORMATION

PLEASE FAX COPY OF INSURANCE CARD (Front & Back)

DIAGNOSIS:
Date of Diagnosis__________

☐ K72.90 Hepatic failure, unspecified without coma
☐ K72.91 Hepatic failure, unspecified with coma
☐ K58.0 Irritable Bowel Syndrome with Diarrhea
☐ Other __________________

HEPATIC ENCEPHALOPATHY

CLINICAL INFORMATION

PREVIOUS TREATMENTS TRIED AND FAILED (Check all that apply or attach list of "Tried and Failed" therapies)

TRIED & FAILED:	Date Start	Date End	TRIED & FAILED:	Date Start	Date End
☐ Lactulose			☐ Neomycin		
☐ Ciprofloxacin			☐ Other		
☐ Metronidazole					

Is the patient currently on therapy for this diagnosis? ☐ Yes ☐ No
Please list current medication(s) and treatment duration(s): ________________

Will the patient be taking lactulose along with this medication? ☐ Yes ☐ No
If no, do either of the following reasons apply? ☐ Inadequate response to lactulose ☐ Intolerance or contraindication to lactulose

Other medications patient is currently taking (including prescription and OTC medications) Please fax medication profile, or list below:
____

Medical history and comorbidities:: ☐ severe hepatic impairment ☐ Other:________________

HEPATIC ENCEPHALOPATHY PRESCRIPTION INFORMATION

Medication, Dosage Form / Strength	Directions	Quantity	Refill
☐ **Xifaxan® (rifaximin) 550mg tablet**	**For Hepatic Encephalopathy:** ☐ Take 1 tablet PO BID ☐ Other:__________	☐ 60 ☐ 180 ☐ _____	☐ _____
☐ Other:__________	☐ __________	☐ _____	☐ _____

IRRITABLE BOWEL SYNDROME WITH DIARRHEA

PREVIOUS TREATMENTS TRIED AND FAILED (Check all that apply or attach list of "Tried and Failed" therapies)

TRIED & FAILED:	Date Start	Date End	TRIED & FAILED:	Date Start	Date End
☐ Dicyclomine (Bentyl)			☐ Antidiarrheals		
☐ Cimetropium			☐ Loperamide (Imodium)		
☐ Hyosyamine (Levsin)			☐ Alosetron (Lotronex)		
☐ Amitriptyline			☐ Diphenoxylate / Atropine (Lomotil)		
☐ Fiber Supplements			☐ Other		

IRRITABLE BOWEL PRESCRIPTION INFORMATION

Medication, Dosage Form / Strength	Directions	Quantity	Refill
☐ **Xifaxan® (rifaximin) 550mg tablet**	**For IBS-D:** ☐ Take 1 tablet PO TID ☐ Other:__________	☐ 42 ☐ _____	☐ _____
☐ Other:__________	☐ __________	☐ _____	☐ _____

Prescriber Certification of Patient Consent

Prescriber Certification of Patient Consent: By signing below, I further certify and warrant that I have fully explained to the patient the details of this Enrollment Form and the program, including that (i) the Pharmacy is a specialty pharmacy that will ship the product directly to the patient's home address and will be calling the patient on a regular basis to help ensure adherence and answer any patient questions, and (ii) the patient may opt-out of this program by providing notice to the Pharmacy at any time. I also certify that I have complied with all applicable laws regarding the patient's personal health information (PHI) and have obtained written authorization from the patient to disclose such PHI for these purposes, including all information relating to the patient's medical conditions and prescription medications disclosed in this Enrollment Form. **Date:** __________

PRESCRIBER SIGNATURE:________________________

PRESCRIBER INFORMATION

Prescriber's Name: ________________ Contact Person:________________

Telephone: ________________ Fax:________________ Email:________________

Office Address:________________ City:____________ State: ______ Zip:________

NPI # : ____________ DEA # : ____________ UPIN # : ____________ Medicaid Provider # : ____________

________________ ________ * ________________

PRESCRIBER'S SIGNATURE (DATE) *IF BRAND DRUGS ARE PREFERRED, HANDWRITE **"BRAND MEDICALLY NECESSARY"** ABOVE

I acknowledge that the ICD-10 Codes, previous treatments, and related information are included in this Enrollment Form for informational purposes only, and that it is the treating physician's responsibility to determine the proper diagnosis, treatment and applicable ICD-10 Code. By signing above, I certify and warrant that this Enrollment Form has been prepared exclusively by me or my office, and that the above prescribing decisions are based on my own independent medical judgment regarding the best interests of the patient. I also hereby authorize the 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 such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

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