XIFAXAN® REFERRAL FORM

BIOMATRIX SPRX **TEL:** 855-359-9679 **FAX:** 610-545-6030

Patient Name _____ SS#_____ DOB _____ ☐ Male ☐ Female
Street Address _____ Apt# _____ City _____ State _____ Zip _____
Daytime Tel _____ Cell _____ Email _____ Height _____ Weight _____ BSA _____
Ship to Patient at ☐ Home ☐ Work OR Patient will pick up at ☐ Physician Office Local Pharmacy Phone_____
Allergies _____ Comorbidities _____
Current Medications (if necessary, please fax a complete list) _____

PRACTICE NAME	ADDRESS	PHONE	PRIMARY CONTACT

PRESCRIBER INFORMATION (PLEASE INCLUDE PHYSICIAN NAME AND NPI#)

☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____
☐ _____ #_____	☐ _____ #_____	☐ _____ #_____

Insured's Name _____ Relation to Patient _____
Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____ Prescription Card ☐ Yes ☐ No If Yes, Carrier _____
Tel _____ Fax _____ Policy/Group# _____
Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Diagnosis: ☐ **K72.91** Hepatic Encephalopathy ☐ **K58.0** Irritable Bowel with Diarrhea
☐ **A04.4** Escherichia Coli Diarrhea ☐ Other ICD-10 _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

XIFAXAN® (RIFAXIMIN) Dose: ☐ 550 mg Tablets

Hepatic Encephalopathy

☐ Take one 550mg tablet by mouth twice a day
QTY: 60 Refills: _____

Irritable Bowel with Diarrhea:

☐ Take one 550mg tablet by mouth three times a day for 14 days, may treat recurrence up to 2 additional times (max of 3 total treatment cycles)
QTY: 42 Refills: _____

Previous Treatments Tried and Failed **(Check all that apply)**

Hepatic Encephalopathy

☐ Ciprofloxacin Start Date: _____ End Date: _____
☐ Lactulose Start Date: _____ End Date: _____
☐ Metronidazole Start Date: _____ End Date: _____
☐ Neomycin Start Date: _____ End Date: _____
Other: _____ Start Date: _____ End Date: _____
Other: _____ Start Date: _____ End Date: _____

☐ **OTHER**
Medication: _____ Dose: _____
SIG:_____ QTY: _____ Refills: _____

☐ **OTHER**
Medication: _____ Dose: _____
SIG:_____ QTY: _____ Refills: _____

☐ **OTHER**
Medication: _____ Dose: _____
SIG:_____ QTY: _____ Refills: _____

By signing this form and utilizing our services, you are authorizing BioMatrix Specialty Pharmacy, its subsidiaries and their employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies where allowed by law or contract.

Prescriber's Signature _____ *(Signature required. NO STAMPS)* **AND** *Hand write: brand medically necessary, if needed* **Date**_____
Prescriber's Email_____