

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#)

<input type="checkbox"/> _____ # _____	<input type="checkbox"/> _____ # _____	<input type="checkbox"/> _____ # _____
<input type="checkbox"/> _____ # _____	<input type="checkbox"/> _____ # _____	<input type="checkbox"/> _____ # _____
<input type="checkbox"/> _____ # _____	<input type="checkbox"/> _____ # _____	<input type="checkbox"/> _____ # _____

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

<input type="checkbox"/> Ciprofloxacin	Start Date: _____	End Date: _____
<input type="checkbox"/> Lactulose	Start Date: _____	End Date: _____
<input type="checkbox"/> Metronidazole	Start Date: _____	End Date: _____
<input type="checkbox"/> 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 _____

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