



XIFAXAN® PRESCRIPTION REFERRAL FORM

210 Rock Rd | Glen Rock, NJ 07452
866-888-3200 TEL: 201-444-3200 FAX: 201-444-5792

Today's Date _____

NEW PATIENT CURRENT PATIENT
July 2016

Patient Name First Name _____ Middle Name _____ Last Name _____ DOB _____ Weight _____ Male Female
 Street Address _____ Apt # _____ City _____ State _____ Zip _____
 Daytime Tel _____ Evening Tel _____ Cell _____ Email _____
 Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Pharmacy Date Needed _____
 ICD-10 Diagnosis K72.91 Hepatic Encephalopathy Other _____
 Allergies _____

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# _____
 Prescriber's Name _____ Office Contact _____
 Street Address _____ Suite # _____ City _____ State _____ Zip _____
 Tel _____ Fax _____ Email _____
 License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

XIFAXAN® (RIFAXIMIN)

Dose: 550mg Tablets

Directions: Take one 550mg tablet orally two times a day

QTY: 60 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: _____

Directions: _____

QTY: _____ Refills: _____

OTHER

Medication: _____

Dose: _____

Directions: _____

QTY: _____ Refills: _____

By signing this form and utilizing our services, you are authorizing Glen Rock Medical Pharmacy and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Please fax completed referral form to **Glen Rock Medical Pharmacy** at **201-444-5792** Visit us at **WWW.GLENROCKMEDICALPHARMACY.COM** for online fillable forms.