XIFAXAN® PRESCRIPTION REFERRAL FORM

GLEN ROCK MEDICAL PHARMACY
A BIOMATRIX Company
210 Rock Rd | Glen Rock, NJ 07452
866-888-3200 TEL: 201-444-3200 FAX: 201-444-5792

FEB 2018

Today's Date

☐ NEW PATIENT ☐ CURRENT PATIENT

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** _____

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