

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 Elwyn Specialty 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** \_\_\_\_\_

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