Elwyn SPECIALTY CARE
A BIOMATRIX Company

FEB 2018

XIFAXAN® PRESCRIPTION REFERRAL FORM

3070 McCann Farm Drive | Suite 101 | Garnet Valley, PA 19060
1-866-317-0672 TEL: 610-545-6040 FAX: 610-545-6030

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 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** _____

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 **Elwyn Specialty Care** at **610-545-6030** Visit us at **WWW.ELWYNSPECIALTYCARE.COM** for online fillable forms.

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