



XIFAXAN & VIBERZI REFERRAL FORM

Updated July 2019

Patient Name, Today's Date, NEW Patient, CURRENT Patient, DOB, Height, Weight, Male, Female, Preferred Language, Best Phone, Email, Street Address, Apt#, City, State, Zip, Ship to Patient at: Home, Physician Office, Work Address, Allergies, Current Medications including OTC's

Please Fax Insurance Card(s) both sides

Insured's Name, Relation to Patient, Primary Insurance, ID#, Group #, Secondary Insurance, ID#, Group #

Ordering Prescriber

Office Contact, Street Address, Suite #, City, State, Zip, Tel, Fax, Email, License#, NPI#

ICD-10 Code, Irritable bowel syndrome with diarrhea (IBS-D), Traveler's diarrhea, Hepatic Failure, Hepatic Encephalopathy, Testing?, Is Patient currently on therapy?, Date of next blood work

PRESCRIPTION

XIFAXAN 550mg TABLETS, SIG: QTY: Refill:

VIBERZI 75mg TABLETS 100mg TABLETS, SIG: QTY: Refill:

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

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

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary. My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

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