XIFAXAN ENROLLMENT FORM

Fax Completed Form To: (877) 577-6447

Nzone-Elite Specialty Pharmacy
10210 101st Ave
Ozone Park, NY 11416
Phone: (718) 880-1783

Date **Ship to** ☐ **Patient** ☐ **Office** ☐ **Other**

PATIENT INFORMATION

(Complete the following *or send patient demographic sheet*)

Patient Name: ______

Address: ______

City, State, Zip: ______

Home Phone: ______

Alternate Phone: ______

Patient SS#: ______

Date of Birth: ______

PRESCRIBER INFORMATION

Prescriber's Name: ______

State License #: ______ NPI: ______

Group or Hospital: ______

Address: ______

City, State, Zip: ______

Phone: ______

Fax: ______

Contact Person: ______

INSURANCE INFORMATION

Other Medications: Current Medication List ______
Dosage ______ Strength ______

Primary Insurance/ Prescription Card:	PLEASE FAX COPY OF INS CARD (FRONT & BACK)	Secondary Insurance/ Prescription Card:	PLEASE FAX COPY OF INS CARD (FRONT & BACK)

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

Please include diagnosis name and ICD-10

______
______
______
______

- Date of Diagnosis: ______

Additional Clinical Information: Therapy: ☐ New ☐ Reauthorization ☐ Restart

- Weight: ______ kg/lbs
- Height: ______ in/cm
- Allergies: ______
- Lab Data: ______
- Concomitant Medications: ______
- Additional Comments: ______

Injection Training/Home Health Coordination:

- Injection training/home health will be/has been conducted/coordinated by the Physician's office. ☐ Yes ☐ No
- If Yes, Date: _____
- Specialty Pharmacy to coordinate injection training/home health nursing. ☐ Yes ☐ No *Agency of Choice: ______

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐				
☐				
☐				
☐				
☐				
☐				
☐				

Any known allergies? ☐ Yes ☐ No List: ______

Patient Will Accept Product Substitution/Generic Yes No

Prescriber Signature (Date)

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