STAR CARE PHARMACY

"The First Wealth is Health"

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Toll Free: 888-216-STAR (7827)

XIFAXAN

Date: _____ Attn: _____

Ship to ❒ Patient ❒ Physician Office ❒ Nurse/Training

Patient Name _____
Address _____ Suite# _____
City _____ State _____ Zip _____
Home Tel _____ Work Tel _____
Cell _____ Email _____
Date of Birth _____ SS# _____
☐ Male ☐ Female Weight _____ Height _____

Prescriber's Name _____
License# _____ DEA# _____
NPI# _____ UPIN# _____
Practice Name _____
Office Contact _____
Address _____ Suite# _____
City _____ State _____ Zip _____
Tel _____ Fax _____

Insurance Information *(Complete or attach copies of cards)*

Primary Insurance: _____
ID#: _____
Group #: _____

Insured's Name: _____
City: _____ State: _____ Phone: ( ) _____ - _____
Employer: _____

Clinical Information – *Please send all available chart notes including lab results*

Primary Diagnosis: ❑K58.0 Irritable Bowel Syndrome with Diarrhea ❑K72.91 Hepatic Encephalopathy ❑A09 Travelers' Diarrhea due to E. coli ❑Other:_____

- Has patient been treated *previously* for this condition? ❑Yes ❑No Please indicate all prior treatments tried and failed:

Irritable Bowel Syndrome with Diarrhea	Dates (Start/End)
❑Antispasmodic: ❑ Dicyclomine (Bentyl) ❑ Cimetropium ❑ Hyosyamine (Levsin)	
❑Diphenoxylate/atropine (Lomotil)	
❑Loperaminde (Imodium)	
❑Lotronex (Alosetron)	
❑Tricyclic antidepressants ❑ Amitriptyline ❑Other: _____	
❑OTC medications ❑Fiber supplements ❑Antidiarrheal	

Hepatic Encephalopathy	Dates (Start/End)
❑Ciprofloxacin	
❑Lactulose	
❑Metronidazole	
❑Neomycin	
❑Other:_____	

SIBO		
❑ Hydrogen Breath Test	❑ Augmentin	
❑ Metronidazole w/Bactrin DS	❑ Tetracycline	❑ Dic

- Is patient *currently* on therapy? ❑Yes ❑ No; Please list current medication(s) and treatment duration(s):_____
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No
  If *yes*, how long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):
  _____
- Patient's medical history includes: ❑Severe hepatic impairment ❑Current pregnancy ❑Other:_____

Prescription Information

❑Xifaxan® 550mg tablet

❑Irritable Bowel Syndrome with Diarrhea: 1 tablet PO three times daily for 14 days QTY: 42 tablets Refills: _____
****if recurrence occurs then patient can be retreated up to 2 times with the same regimen****

❑Hepatic Encephalopathy: 1 tablet PO two times daily QTY: _____ tablets Refills: _____

❑ **SIBO** 1 tablet PO three times daily x 14 days QTY: 42 tablets Refills: _____

PRESCRIBER SIGNATURE (PLEASE SIGN AND DATE BELOW)

***Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms, the receipt and submission of patient lab values and other patient data including pursuing available copay and financial assistance on behalf of my patients. If this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product substitution permitted ☐ Dispense as Written

Prescriber Signature: _____ _____
Date

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