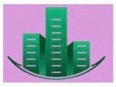
**Xifaxan Enrollment Form** ☐ **New Patient**



**believeRX**

Phone (865) 214-6672 9627 Countryside Center Lane Knoxville, TN 37931 Fax (865) 999-7825 NPI 1053876896

**Patient Information:**

| Patient Name: | DOB | SSN | Phone Number |
|---|---|---|---|
| Address: | City | State | Zip |
| Sex: ☐ Male ☐ Female | | Weight: kg/lbs. | Height: cm/in |
| Allergies: | | | |

**Clinical Information:** **Please include diagnosis name with ICD-10 Code**

| **ICD-10 Code:** | **Diagnosis:** | **Previous Therapy:** | **More Information about previous therapy:** |
|---|---|---|---|
| ☐ **K72.91** | Hepatic Encephalopathy | | |
| ☐ **K58.00** | Irritable Bowel Syndrome | | |
| ☐ **R19.7** | Traveler's Diarrhea | | |
| ☐ Other: | | | |

**Prescription Information:**

| **Indication:** | **Dose/Strength** | **Directions** | **Quantity** | **Refills** |
|---|---|---|---|---|
| ☐ **Hepatic Encephalopathy** | ☐ 550mg | 550 mg by mouth twice daily | ☐ #60 | |
| ☐ **IBS-D** | ☐ 550mg | 550mg by mouth three times a day for 14 days | ☐ #42 | |
| ☐ **Traveler's Diarrhea** | ☐ 200mg | 200mg by mouth three times daily for 3 days | ☐ #9 | |

**Doctor Information:**

| Prescribers Name | NPI# | Phone# | Fax# |
|---|---|---|---|
| Address | City | State | Zip |
| DEA# | | | |

_____ _____

Prescribers Signature Date

I authorize believeRX to act as an agent to initiate and execute the prior authorization for this prescription and future fills of the same prescription for the patient listed above.

I understand that I can revoke this designation at any time by providing written notice to believeRX.