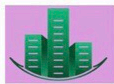


Xifaxan Enrollment Form

☐ 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: <input type="checkbox"/> Male <input type="checkbox"/> 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:
<input type="checkbox"/> K72.91	Hepatic Encephalopathy		
<input type="checkbox"/> K58.00	Irritable Bowel Syndrome		
<input type="checkbox"/> R19.7	Traveler's Diarrhea		
<input type="checkbox"/> Other:			

Prescription Information:

Indication:	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Hepatic Encephalopathy	<input type="checkbox"/> 550mg	550 mg by mouth twice daily	<input type="checkbox"/> #60	
<input type="checkbox"/> IBS-D	<input type="checkbox"/> 550mg	550mg by mouth three times a day for 14 days	<input type="checkbox"/> #42	
<input type="checkbox"/> Traveler's Diarrhea	<input type="checkbox"/> 200mg	200mg by mouth three times daily for 3 days	<input type="checkbox"/> #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.

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