Giant Eagle Specialty Pharmacy

Phone: 1-844-259-1891
Fax: 1-877-645-4142

To ePrescribe send prescription to:
Giant Eagle Pharmacy (#8991)
2500 Lovi Road
Freedom, PA 15042

XIFAXAN ENROLLMENT FORM

Today's Date: _____

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up **Date Shipment Needed:**_____ **Rx:** ☐ New ☐ Refill **RN Instruction Needed:** ☐ Yes ☐ No
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Date: _____ ☐ Male ☐ Female DOB:_____
Patient's First Name: _____ Patient's Last Name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Best Phone Number: _____ Alternate Phone Number: _____
Height:_____ Weight: _____ ☐ kgs. or ☐ lbs. Recorded Date: _____
Caregiver: _____ Caregiver Contact Number: _____
Allergies: _____
Store Preference (address): _____
Discharge Date: _____
Emergency Contact Name: _____ Emergency Contact Phone #: _____

Insurance Information: Please fax copy of insurance card (front + back)

Medical Assessment

Primary Diagnosis/ICD-10 ☐ **K58.0 Irritable Bowel Syndrom with Diarrhea** ☐ **K72.91 Hepatic Encephalopathy**
☐ **A09 Travelers' Diarrhea due to E.coli** ☐ **Other** _____
Has parient been treated previously for this condition? ☐ Yes ☐ No Please indicate all prior treatment tried and failed:

Irritable Bowel Syndrome with Diarrhea	Dates (Start/End)	Hepatic Encephalopathy	Dates (Start/End)
Antispasmodic: ☐ Dicyclomine (Bentyl) ☐ Cimetropium ☐ Hyosyamine (Levsin) ☐ Diphenoxylate/atropine (Lomobl) ☐ Loperaminde (Impodium) ☐ Lotronex (Alosetron) ☐ Tricyclic antidepressants ☐ Amitriptyline ☐ Other:_____ ☐ OTC medications ☐ Fiber supplements ☐ Antidiarrheal		☐ Ciprofloxacin ☐ Lactulose ☐ Metronidazole ☐ Neomycin ☐ Other: _____	

Is patient *currently* on therapy? ☐ Yes ☐ No
Please list current medication(s) and treatment duration(s): _____

Will patient stop taking the above mediction(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: ☐ Sever hepatic impairment ☐ Current pregnancy
☐ Other: _____

Prescription

☐ **Xifaxan® 550mg Tablet** ☐ **Irritable Bowel Syndrome with Diarrhea:** 1 tablet PO three times daily for 14 days ☐ **Hepatic Encephalopathy:** 1 tablet PO two times daily	Qty: _____ Refill: _____ Qty: _____ Refill: _____
☐ **Xifaxan® 200mg Tablet** ☐ **Travelers' Diarrhea due to E.coli:** 1 tablet PO three times daily for 3 days	Qty: _____ Refill: _____
☐ **Other:** _____	Qty: _____ Refill: _____

Prescriber Information

Date Prescription Needed: _____
Physician Name (please print): _____ Contact Name: _____
Phone #: _____ Fax #:_____ NPI #: _____
Office Address: _____ City: _____ State: _____ ZIP: _____
State License #: _____DEA #: _____Tax ID #:_____
In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below.
_____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: _____ **Date:** _____