XIFAXAN REFERRAL FORM

Phone : (747) 900-8488
Fax : (747) 900-8489
19944 Ventura BLVD,
Woodland Hills, CA 91364

Patient Name: ______________________________ **DOB:** ________________ **Sex** □ M □ F

Address: ____ **Phone:** _________________________

Alt Phone: ___________________________**Height:**________________ **Weight:**________________

Insurance: __________________________ **ID** _________________ **BIN**__________ **PCN**________

(Please fax demographics, clinic notes & labs) **Ship to:** □ Physician's office □ Patient

CLINICAL INFORMATION

Diagnosis code: □ K72.90 Hepatic Encephalopathy □ K58.0 Irritable Bowel Syndrome with Diarrhea (IBS-D)

Date of Diagnosis: ______________________ Allergies: _________________________ □ NKDA

Prior treatment: ____

PRESCRIPTION INFORMATION

○

Directions: □ Take 1 tablet by mouth 3 times a day for 14 days.

□ ____

Quantity: ____________________ **Refills:** ____________________

DRUG	DIRECTIONS	REFILLS	QTY
□			
□			

Physician's SignatureX: ____________________________ □ **DAW** *(Dispense as written)* **Date:** ______________

Physician's Name: ____ **Office Contact:** ________________

Physician's Address: ____

Phone: ___________________ **Fax:** __________________ **NPI:**__________________ **DEA:** ____________

By signing this form and utilizing our services, you are authorizing Southside pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Fax your referral to (747) 900-8489