PATIENT ENROLLMENT FORM
XIFAXAN®
(rifaximin) 550 mg tablets

Please fax completed form to: 1-800-387-5807 • Phone: 1-866-XIFAXAN (943-2926 option 1)

Patient Information

Last Name: First Name: MI:

Address:

City: State: Zip Code:

Telephone #: SSN: - -

Gender: Date of Birth: / /

☐ Copy of demographic sheet attached
☐ Copy of insurance cards attached (Medical and Rx)

Patient Insurance Information

Medical Card

Insurer Name:	Insurer Phone #:
Member ID:	Group #:

☐ Patient has Medicare and Medicaid (low income subsidy)

Prescription Card

Name:	BIN #:
Member ID:	PCN #:

Policy Holder Name (if different from Patient):

Patient Diagnosis Code

Irritable Bowel Syndrome with Diarrhea (IBS-D)	Hepatic Encephalopathy (HE)

Treatment Information

XIFAXAN 550 mg Tablets
(rifaximin)

☐ **Hepatic Encephalopathy**
☐ **Irritable Bowel Syndrome with Diarrhea**

Refills: _____ Dosing: _____

Provider Information

Provider Name:

Site Name:

Contact Name: Contact Phone #:

Provider Specialty

☐ Gastroenterologist ☐ Hepatology ☐ Internal Medicine
☐ PCP ☐ Other: _____

TIN #: NPI #:

Medicaid Provider #: State License #:

Address:

City: State: Zip Code:

Telephone #: Fax #:

☐ Copy of medication history attached

Previous Treatments Tried and Failed

(Check all that apply below)

***To support payer coverage requirements, please attach a list of "Tried and Failed" therapies.**

Irritable Bowel Syndrome with Diarrhea	Dates (Start/End)
☐ Antispasmodics: ☐ Dicyclomine (Bentyl) ☐ Cimetropium ☐ Hyosyamine (Levsin)	
☐ Trycyclic Antidepressants: ☐ Amitriptyline ☐ Other: _____	
☐ Lotronex (alosetron)	
☐ Diphenoxylate/Atropine (Lomotil)	
☐ Loperamide (Imodium)	
☐ OTC Medications: ☐ Fiber supplements ☐ Antidiarrheals	
☐ Other: _____	
Hepatic Encephalopathy	**Dates (Start/End)**
☐ Ciprofloxacin	
☐ Lactulose	
☐ Metronidazole	
☐ Neomycin	
☐ Other: _____	

Healthcare Provider's Signature **Date**

By my signature, I certify that I am a physician or a healthcare provider authorized to sign on behalf of a physician and authorize the Salix Reimbursement Helpline and its agents (the "Helpline") to use any information provided on this form for the purposes of verifying coverage and benefits for XIFAXAN, or referring the patient to the XIFAXAN Patient Assistance Program in the event the patient does not have insurance. I certify that I have a signed copy on file of this patient's authorization (in a form that complies with all applicable state and federal laws) that allows me and the patient's health insurers to use and disclose the patient's health information, including his or her medical and insurance coverage information and records, to the Helpline, the XIFAXAN Patient Assistance Program, and their respective agents. I understand and agree that I remain responsible for complying with all applicable federal and state laws regarding patient privacy. The authorization form signed by the patient that I have on file informs the patient that: (a) the information disclosed may include the patient's health status; (b) the patient's information may be subject to re-disclosure by the recipients and no longer protected by state or federal privacy laws; (c) I will not condition the patient's treatment, payment, enrollment in a health plan, or eligibility for benefits on the patient providing the requested authorization; (d) the patient has the right to revoke the authorization at any time by calling the Helpline at 1-866-XIFAXAN; (e) such revocation would end the patient's eligibility to participate in the program; and (f) if the patient revokes the authorization, the revocation will prohibit disclosures after the date the written revocation is received, but will not affect previous disclosures made in reliance on the patient's authorization. The patient's signature will be maintained and available for audit purposes as required by all applicable state and federal privacy laws. To the best of my knowledge, all information contained in this form is correct and complete and consistent with applicable privacy laws and regulations, and I understand that the Helpline is relying on this representation. I further certify that I made the above prescribing decisions based on my own independent medical judgment regarding what is in the best interests of the patient.

Click here for Prescribing Information or see accompanying Prescribing Information.