

ST. JUDE

SPECIALTY PHARMACY
& MEDICAL SUPPLIES

XIFAXAN PRESCRIPTION REFERRAL FORM

121 St. Nicholas Ave Brooklyn, NY 11237

TEL: 718-381-5116 FAX: 718-417-3621

Proudly serving over 30 years

Today's Date

NEW PATIENT CURRENT PATIENT

Patient Name First Name _____ Middle Name _____ Last Name _____ DOB _____ Weight _____ Male Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Daytime Tel _____ Evening Tel _____ Cell _____ Email _____

Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Pharmacy Date Needed _____

ICD-9 Code _____ Diagnosis _____ Allergies _____

Testing Yes No Results _____ Patient currently on therapy Yes No Date of next blood work _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare Yes No If yes, Medicare# _____

Prescription Card Yes No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____

Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

XIFAXAN® (RIFAXIMIN) 550mg TABLETS

Quantity	Directions for use	Refills	Signature

OTHER # 1

Medication	Dosage	Quantity	Directions for use	Refills	Signature

OTHER # 2

Medication	Dosage	Quantity	Directions for use	Refills	Signature

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

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