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**

Please fax completed form to St. Jude at **718-417-3621**

Visit us at **www.stjuderx.com** for online fillable forms.