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

Date:__________

☐ NEW PATIENT
☐ CURRENT PATIENT

ACCREDITED
Specialty Pharmacy

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-10 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** ____________

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

PLEASE NOTE: St. JUDE can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.

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

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