

# BERGEN AVE DRUGS XIFAXAN & VIBERZI PRESCRIPTION REFERRAL FORM

Specialty Pharmacy

745 Bergen Ave | Jersey City, NJ, 07306  
Tel 201.521.0545 | Fax 201.521.0546

Today's Date

NEW PATIENT  CURRENT PATIENT

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Last updated: May 2017

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:  K58.0 Irritable bowel syndrome with diarrhea (IBS-D)  A09 Traveler's diarrhea  K72 Hepatic Failure, Hepatic Encephalopathy  
 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
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VIBERZI  75mg TABLETS  100mg TABLETS

Quantity	Directions for use	Refills	Signature
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OTHER # 1

Medication	Dosage	Quantity	Directions for use	Refills	Signature
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ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

Prescriber's Signature (signature required. NO STAMPS) \_\_\_\_\_ Date \_\_\_\_\_

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