Completing the Patient Information Form

❶ Patient information

It's essential that the patient's personal information is accurate.

❷ Insurance coverage

You can either fill out the insurance information OR check this box and submit a copy of the patient's insurance card.

❸ Notify patient

Check this box if the patient wishes to be contacted on the status of their claim.

❹ Patient's signature

Have patient sign the form. If the form is not signed, Helpline staff will contact the patient directly for permission to proceed.

This section is VERY IMPORTANT for review of coverage. Please ensure that it has been completed in full.

❺ Diagnosis

For what medical condition is the patient being treated?

❻ ICD-9

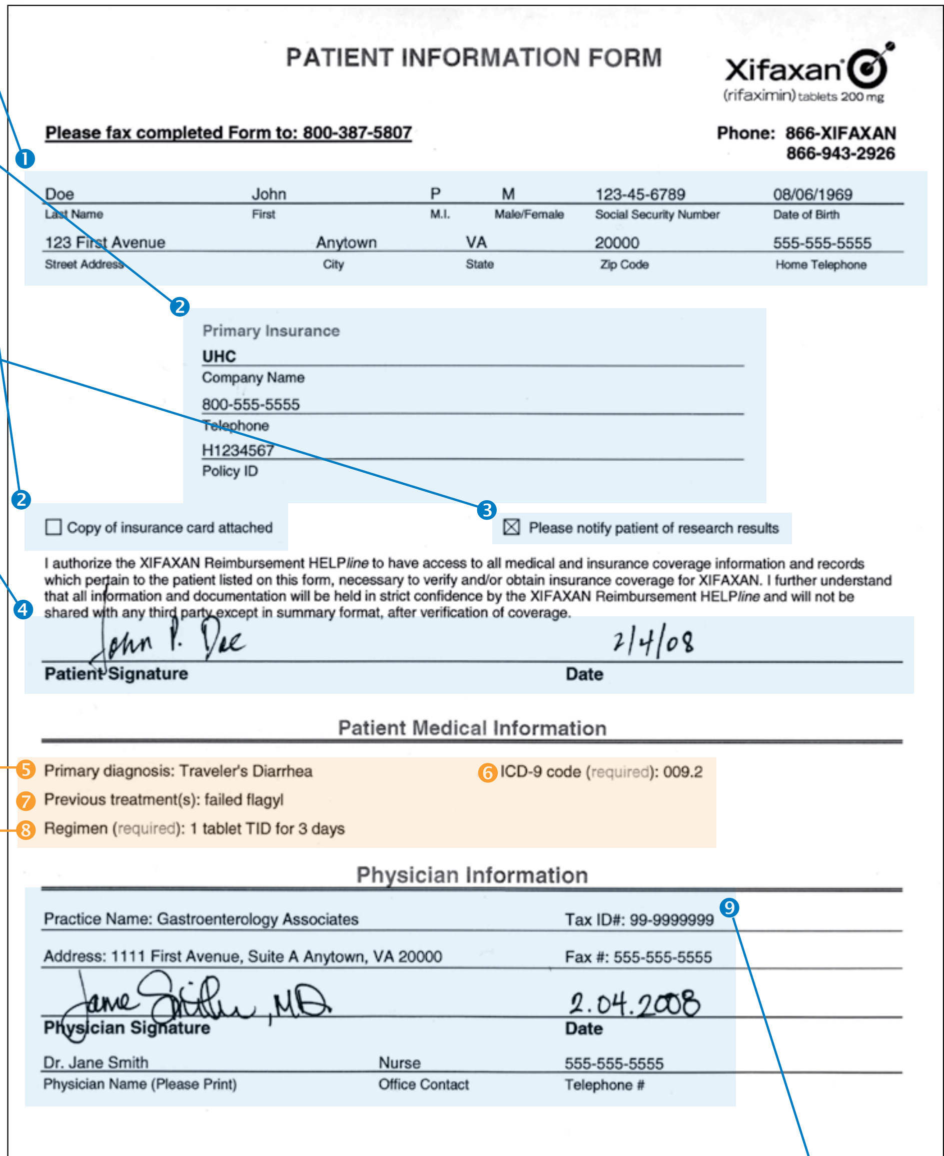
What is the ICD-9 code associated with this disease state?

❼ Previous treatments

If patient has been treated for this condition before, what medications were used and what was the outcome?

❽ Regimen

What is the complete dosing regimen to treat the condition?



PATIENT INFORMATION FORM

Xifaxan (rifaximin) tablets 200 mg

Please fax completed Form to: 800-387-5807

Phone: 866-XIFAXAN 866-943-2926

Last Name	First	M.I.	Male/Female	Social Security Number	Date of Birth
Doe	John	P	M	123-45-6789	08/06/1969

Street Address	City	State	Zip Code	Home Telephone
123 First Avenue	Anytown	VA	20000	555-555-5555

Primary Insurance

Company Name: UHC

Telephone: 800-555-5555

Policy ID: H1234567

☐ Copy of insurance card attached

☒ Please notify patient of research results

I authorize the XIFAXAN Reimbursement HELP*line* to have access to all medical and insurance coverage information and records which pertain to the patient listed on this form, necessary to verify and/or obtain insurance coverage for XIFAXAN. I further understand that all information and documentation will be held in strict confidence by the XIFAXAN Reimbursement HELP*line* and will not be shared with any third party except in summary format, after verification of coverage.

Patient Signature: John P. Doe   Date: 2/4/08

Patient Medical Information

Primary diagnosis: Traveler's Diarrhea   ICD-9 code (required): 009.2

Previous treatment(s): failed flagyl

Regimen (required): 1 tablet TID for 3 days

Physician Information

Practice Name: Gastroenterology Associates   Tax ID#: 99-9999999

Address: 1111 First Avenue, Suite A Anytown, VA 20000   Fax #: 555-555-5555

Physician Signature: Jane Smith, MD   Date: 2.04.2008

Physician Name (Please Print)	Office Contact	Telephone #
Dr. Jane Smith	Nurse	555-555-5555

❾ Physician/Practice information

The physician must sign and date this form in order for it to be valid for submission.

XIFAXAN Reimbursement Fax Line: 1-800-387-5807

SAFETY CONSIDERATIONS

Xifaxan® (rifaximin) Tablets are indicated for the treatment of patients (≥12 years of age) with travelers' diarrhea caused by non-invasive strains of *Escherichia coli*. Xifaxan should not be used in patients with diarrhea complicated by fever or blood in the stool or diarrhea due to pathogens other than *Escherichia coli*. Xifaxan should be discontinued if diarrhea symptoms get worse or persist more than 24-48 hours and alternative antibiotic therapy should be considered.

In clinical trials, Xifaxan was generally well tolerated. The most common side effects (vs. placebo) were flatulence 11.3% (vs. 19.7%), headache 9.7% (vs. 9.2%), abdominal pain 7.2% (vs. 10.1%), rectal tenesmus 7.2% (vs. 8.8%), defecation urgency 5.9% (vs. 9.2%), and nausea 5.3% (vs. 8.3%).

Please see accompanying complete Prescribing Information.

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