DELTADRUGS

# Hepatic Encephalopathy

437 Fernando Court • Glendale, CA 91204 • **MAIN:** 818.309.2884 • **FAX:** 818.309.1704 • www.deltadrugs.com

## PATIENT INFORMATION

Patient Name: _____ Patient SSN#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ 2nd Phone #: _____ Date of Birth: _____ Gender: ❑ Male ❑ Female

Weight (lbs): _____ Height (in.): _____ Allergies: _____

Primary Insurance: _____ Secondary Insurance: _____

ID#: _____ Phone #: _____ ID#: _____ Phone #: _____

**FAX COPY OF INSURANCE CARD (FRONT & BACK)**

## CLINICAL INFORMATION

ICD-10 Diagnosis

❑ K72.90 Hepatic Encephalopathy

❑ K58.0 Irritable Bowel Syndrome-D

Comorbidities:

_____

Medication Reconciliation:

_____

Prior Medication History

❑ Dicyclomia ❑ Antisposmodic ❑ Imodium

❑ Alosetron ❑ Alvimopan ❑ Asacol ❑ Atropine/Diphenoxylate

❑ Kaopectate ❑ Lactulose ❑ Loperamide ❑ Mesalamine ❑ Metoclopramide ❑ Pepto-Bismol

Failed due to:

❑ Failed to treat diarrhea ❑ Nausea ❑ Vomiting ❑ Severe diarrhea ❑ Severe gas

❑ Gastric reflux

**FAX COPY OF ALL RELATED CLINICAL/LAB INFO**

| MEDICATION | STRENGTH | DIRECTIONS | QTY | REFILLS |
|---|---|---|---|---|
| ❑ XIFAXAN® | ❑ 550 mg | ❑ 1 tablet by mouth twice a day | ❑ 60 | 2 |

Ship to: ❑ Physician's Office ❑ Patient's Home | ❑ Dispense As Written

## PHYSICIAN INFORMATION

Physician Name: _____ Contact: _____ NPI#: _____

Address: _____
Address, City, State, Zip Code

Phone #: _____ Fax#: _____ Email: _____

Physician's Signature: _____ Date: _____

**I AUTHORIZE DELTA DRUGS AND ITS REPRESENTATIVES TO ACT AS AN AGENT TO INITIATE AND EXECUTE THE INSURANCE PRIOR AUTHORIZATION PROCESS.**