OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

Drug Requested: **Xifaxan®** (rifaximin)

DRUG INFORMATION: ***Complete information below. Authorization process will be delayed if incomplete.***

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable*:** _____

CLINICAL CRITERIA*: *Check below ALL that apply. Boxes must be checked to qualify or authorization process will be delayed. Chart notes and lab results MUST be attached to this request.

Diagnosis:	❑ **Hepatic Encephalopathy**	❑ **Irritable bowel syndrome with Diarrhea**	❑ **Traveler's Diarrhea**	❑ **Other:** _____
Trial and Failure:	❑ Lactulose - 20 to30g (30 to 45mL) 3 to 4 times daily			_____
Dose	❑ 550mg BID daily	❑ 550mg TID for 14 days only	❑ 200mg TID for 3 days only	_____
Re-Auth		❑ Another 14days only. Has 4 months elapsed since last Xifaxan® dose	❑ Last dose: _____ Approval will be 3 days only	

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee:** 2/18/2016
REVISED/UPDATED: ~~5/9/2016; 5/27/2016; 8/12/2016; 12/20/2016;~~ **8/21/2017**