

## Xifaxan® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NP#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>Select the diagnosis below:</b> <input type="checkbox"/> Hepatic encephalopathy <input type="checkbox"/> Irritable bowel syndrome with diarrhea <input type="checkbox"/> Traveler's diarrhea <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Hepatic encephalopathy:</b> Has the patient had a trial and failure of Lactulose 20 to 30g (30 to 45mL) 3 to 4 times daily? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Reauthorization for irritable bowel syndrome with diarrhea:</b> Have four months elapsed since the last Xifaxan dose? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Quantity limit requests:</b> What is the quantity requested per MONTH? _____ Previous therapies failed and/or therapies currently used in combination with the requested medication ( <i>List ALL medications tried or authorization process will be delayed</i> ): _____ _____ _____ Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>Yes</b> , please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature). <b>** Please note: Chart documentation of the above is required to be submitted along with this fax</b> _____ _____					
<b>**Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.**</b> <b>*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*</b>					
Prescriber Signature: _____			Date: _____		

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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