pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

XIFAXAN (rifaximin) (non-preferred) PRIOR AUTHORIZATION FORM

Antibiotics, GI and Related Agents (including Xifaxan) and **Quantity Limits/Daily Dose Limits** prior authorization guidelines are accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: Xifaxan tablet	Strength: ☐200 mg ☐550 mg ☐ _____		
Dose/directions: ☐200 mg three times daily x 3 days ☐550 mg twice daily ☐550 mg three times daily x 14 days ☐other: _____		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Initial requests complete sections applicable to beneficiary's diagnosis

1. ***Hepatic encephalopathy*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of **lactulose**?	☐Yes ☐No	*Submit documentation.*
2. ***Travelers' diarrhea*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐azithromycin (Zithromax) ☐fluoroquinolones (e.g., ciprofloxacin, levofloxacin)	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
3. ***Irritable bowel syndrome with diarrhea (IBS-D):*** Is Xifaxan being prescribed by, or in consultation with, a gastroenterologist?	☐Yes ☐No	*Submit documentation of consultation, if applicable.*
4. ***IBS-D:*** Have other causes of chronic diarrhea been ruled out, such as inflammatory bowel disease, malabsorption syndromes, chronic infection, celiac disease, malignancy, etc.?	☐Yes ☐No	*Submit documentation of differential diagnosis.*
5. ***IBS-D:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following medications? *Check all that apply.* ☐anti-diarrheals (e.g., loperamide) ☐antispasmodics (e.g., dicyclomine)	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
6. ***IBS-D:*** Did the beneficiary try and fail standard IBS-D dietary modifications (e.g., avoidance of lactose, gluten, and artificial sweeteners; low FODMAP diet)?	☐Yes ☐No	*Submit documentation of dietary changes tried and outcomes.*
7. ***All other diagnoses:*** Submit medical literature supporting the use of Xifaxan for the beneficiary's diagnosis and all treatment regimens tried.		

RENEWAL requests

1. ***Irritable bowel syndrome with diarrhea (IBS-D):*** Was the beneficiary's previous treatment course with Xifaxan successful?	☐Yes ☐No	*Submit documentation of clinical response.*
2. ***IBS-D:*** Have the beneficiary's symptoms of IBS-D recurred since the previous treatment course?	☐Yes ☐No	*Submit documentation.*
3. ***IBS-D:*** How many treatment courses of Xifaxan has the beneficiary had? *Submit documentation.*	☐one ☐two ☐other: _____	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: