

XIFAXAN (rifaximin) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antibiotics, GI and Related Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: Xifaxan tablet	Strength: <input type="checkbox"/> 200 mg <input type="checkbox"/> 550 mg <input type="checkbox"/> _____	Quantity:	Refills:
Dose/directions: <input type="checkbox"/> 200 mg three times daily x 3 days <input type="checkbox"/> 550 mg three times daily x 14 days <input type="checkbox"/> 550 mg twice daily <input type="checkbox"/> other: _____			
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	

INITIAL requests - complete questions applicable to beneficiary's diagnosis

<u>Hepatic encephalopathy:</u> Does the beneficiary have a history of trial and failure, contraindication, or intolerance of lactulose?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
<u>Travelers' diarrhea:</u> Does the beneficiary have a history of trial and failure, contraindication, or intolerance of azithromycin (Zithromax)?	<input type="checkbox"/> Yes <i>Submit documentation of all medications tried and outcomes.</i> <input type="checkbox"/> No
<u>Irritable bowel syndrome with diarrhea (IBS-D):</u> Is Xifaxan being prescribed by, or in consultation with, a gastroenterologist?	<input type="checkbox"/> Yes <i>Submit documentation of consultation, if applicable.</i> <input type="checkbox"/> No
<u>IBS-D:</u> Have other causes of chronic diarrhea been ruled out, such as inflammatory bowel disease, malabsorption syndromes, chronic infection, celiac disease, malignancy, etc.?	<input type="checkbox"/> Yes <i>Submit documentation of differential diagnosis.</i> <input type="checkbox"/> No
<u>IBS-D:</u> Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following medications? <i>Check all that apply.</i> <input type="checkbox"/> antispasmodics (e.g., dicyclomine) <input type="checkbox"/> bile acid sequestrants (e.g., cholestyramine)	<input type="checkbox"/> Yes <i>Submit documentation of all medications tried and outcomes.</i> <input type="checkbox"/> No
<u>IBS-D:</u> Did the beneficiary try and fail standard IBS-D dietary modifications (e.g., avoidance of lactose, gluten, and artificial sweeteners; low FODMAP diet)?	<input type="checkbox"/> Yes <i>Submit documentation of dietary changes tried and outcomes.</i> <input type="checkbox"/> No
<u>All other diagnoses:</u> Submit medical literature supporting the use of Xifaxan for the beneficiary's diagnosis and all treatment regimens tried.	

RENEWAL requests

<u>Irritable bowel syndrome with diarrhea (IBS-D):</u> Was the beneficiary's previous treatment course with Xifaxan successful?	<input type="checkbox"/> Yes <i>Submit documentation of clinical response.</i> <input type="checkbox"/> No
<u>IBS-D:</u> Have the beneficiary's symptoms of IBS-D recurred since the previous treatment course?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
<u>IBS-D:</u> How many treatment courses of Xifaxan has the beneficiary had? <i>Submit documentation.</i>	<input type="checkbox"/> one <input type="checkbox"/> two <input type="checkbox"/> other: _____

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

Prescriber Signature:	Date:
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