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

ANTIBIOTICS, GI and RELATED AGENTS – 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.

☐New request ☐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:		City/State/Zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

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

INITIAL requests – complete questions applicable to beneficiary's diagnosis

Hepatic encephalopathy: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of lactulose?	☐Yes ☐No	*Submit documentation.*
Travelers' diarrhea: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of azithromycin (Zithromax)?	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
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.*

RENEWAL requests – complete questions applicable to beneficiary's diagnosis

Irritable bowel syndrome with diarrhea (IBS-D): Was the beneficiary's previous treatment course with Xifaxan successful?	☐Yes ☐No	*Submit documentation of clinical response.*
IBS-D: Have the beneficiary's symptoms of IBS-D recurred since the previous treatment course?	☐Yes ☐No	*Submit documentation.*
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: