CONTAINS CONFIDENTIAL PATIENT INFORMATION

Xifaxan (rifaximin)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: ______	Prescribing Physician: ______
Patient ID #: ______	Physician Address: ______
Patient DOB: ______	Physician Phone #: ______
Date of Rx: ______	Physician Fax #: ______
Patient Phone #: ______	Physician Specialty: ______
Patient Email Address: ______	Physician DEA: ______
	Physician NPI #: ______
	Physician Email Address: ______

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Xifaxan (rifaximin)	______	______	Specify: ______

7. DIAGNOSIS: ______

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY
NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Travelers' Diarrhea:

□ Yes □ No Patient has a diagnosis of travelers' diarrhea

□ Yes □ No Diagnosis is complicated by fever or blood in the stool or diarrhea due to pathogens other than Escherichia coli

□ Yes □ No Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with a preferred generic fluoroquinolone or azithromycin **If No:**

□ Yes □ No Documented* evidence is provided that the use of these agents would be medically contraindicated

□ Yes □ No Patient is 12 years of age or older

A maximum 3 day course of therapy (9 tablets) of the 300mg tablet per 30 days will be allowed.

Hepatic Encephalopathy:

□ Yes □ No Patient has a diagnosis of hepatic encephalopathy

□ Yes □ No Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with lactulose **If No:**

□ Yes □ No Documented* evidence is provided that the use of these agents would be medically contraindicated

□ Yes □ No Patient is 18 years of age or older

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Patient Name: ________________________________ **Patient ID#:** ________________________________

Irritable Bowel Syndrome with Diarrhea:

☐ Yes ☐ No Patient has a diagnosis of irritable bowel syndrome with diarrhea

☐ Yes ☐ No Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with a preferred antispasmotic agent (dicyclomine, hyoscyamine) **If No:**

☐ Yes ☐ No Documented* evidence is provided that the use of these agents would be medically contraindicated

☐ Yes ☐ No Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with amitriptyline and loperamide **If No:**

☐ Yes ☐ No Documented* evidence is provided that the use of these agents would be medically contraindicated

☐ Yes ☐ No Patient is 18 years of age or older

If criteria for coverage are met, a single 14-day course will be approved.

Requests for continued therapy for irritable bowel syndrome with diarrhea:

☐ Yes ☐ No Documentation* of recurrence of IBS-D symptoms is provided

☐ Yes ☐ No Previous treatment and all treatment dates are provided

***Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.**

9. PHYSICIAN SIGNATURE

____ ________________________________

Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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