





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. MEDIO	CATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS		
Xifaxar	n (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:						
Travelers		at and definition out the appropriate	e to your patient & MAT AFFEC	THE OUTCOME OF this request.		
	s' Diarrhea:	as a diagnosis of travelers' dia		THE OUTCOME OF this request.		
□ Yes	s ['] Diarrhea: □ No Patient h	as a diagnosis of travelers' dia		·		
□ Yes □ Yes	s ['] Diarrhea: □ No Patient h □ No Diagnosi Escheric □ No Patient h	as a diagnosis of travelers' dia is is complicated by fever or b hia coli	arrhea lood in the stool or diarrhea du uate trial and therapy failure at	e to pathogens other than		
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PAGE 1 OF 2 CONTINUED ON PAGE 2



Patient Name:

destruction of these documents.





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Provider Help Desk 1-800-454-3730

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 criter	ia for cove	erage 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					
	er or Authorize				
medications provider ce	s are appropriate rtifies that the inf	fits 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 e for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting formation 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.			
for the us party unle If you are	se of the indivess required to e not the inte	ompanying this transmission may contain confidential health information that is legally privileged. This information is intended only vidual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other to do so by law or regulation. Ended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of pricity prohibited. If you have received this information in error, please potify the sender immediately and arrange for the return or			