PRIOR AUTHORIZATION REQUEST

Xifaxan

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to question 8) [] Continuation (If checked, go to question 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
3	Has the patient been receiving medication samples of the requested medication?	Yes	No

If you have any questions, call: 1-888-258-8250

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	[If yes, skip to question 8.]		
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [NOTE: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
5	What is the diagnosis or condition? [] Hepatic Encephalopathy (HE) (If checked, go to 6) [] Travelers Diarrhea (TD) (If checked, no further questions) [] Irritable Bowel Syndrome with Diarrhea (IBS-D) (If checked, no further questions) [] Other (If checked, no further questions)		
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	What is the diagnosis or condition? [] Hepatic Encephalopathy (HE) (If checked, go to 9) [] Travelers Diarrhea (TD) (If checked, go to 12) [] Irritable Bowel Syndrome with Diarrhea (IBS-D) (If checked, go to 17) [] Other (If checked, no further questions)		
9	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
10	Has the patient tried and failed a maximally tolerated dose of lactulose for at least 3 months or has documentation been provided to confirm that the patient had an intolerance to or has a contraindication to lactulose? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Is the medication being prescribed by or in consultation with a gastroenterologist	Yes	No

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	or a physician who specializes in the management of gastrointestinal disease? [No further questions.]		
12	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
13	Does the provider attest the patient is afebrile? [If no, no further questions.]	Yes	No
14	Does the provider attest the patient does not have any blood in the stool? [If no, no further questions.]	Yes	No
15	Has documentation been submitted indicating the causative microorganism is Escherichia coli? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Has the patient tried and failed all formulary antibiotics including azithromycin and one fluoroquinolone (levofloxacin or ciprofloxacin) or has documentation been provided to confirm that the patient had an intolerance to or has a contraindication to all formulary antibiotics? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
17	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
18	Has the patient tried and failed maximally tolerated doses of ALL the preferred formulary antispasmodic agents (dicyclomine AND hyoscyamine) or has documentation been provided to confirm that the patient had an intolerance to or has a contraindication to the preferred formulary antispasmodic agents? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Has the patient tried and failed a maximally tolerated dose of loperamide or has documentation been provided to confirm that the patient had an intolerance to or has a contraindication to loperamide? ACTION REQUIRED: Submit supporting documentation.	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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