

XIFAXAN (Non-Preferred)
PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Xifaxan, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter - Antibiotics, Gastrointestinal: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information (PA#: _____)
Number of Pages in this Request: _____ Office Contact Name: _____ & Phone: (____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____
NPI#: _____ OR MA Provider ID#: _____ State License#: _____
Prescriber Address: _____ Suite #: _____
City/State/Zip: _____ Phone: (____) _____ Fax: (____) _____
Long-term care facility (if applicable) contact name: _____ Phone: (____) _____

MEDICAL INFORMATION

Xifaxan Tablet Strength: 200 mg 550 mg Quantity: _____ Refills: _____

Dosing: 200 mg TID x 3 days 550 mg BID 550 mg TID x 14 days Other: _____

Diagnosis: hepatic encephalopathy irritable bowel syndrome with diarrhea travelers' diarrhea Other: _____

Diagnosis Code: _____ (required)

Hepatic encephalopathy requests:

- Does the Recipient have documentation of a diagnosis of hepatic encephalopathy? Yes – submit documentation No
- Has the Recipient tried and failed (or have a contraindication or intolerance to) lactulose for the treatment of this condition? Yes – submit documentation No

Travelers' diarrhea requests:

- Does the Recipient have documentation of a diagnosis of travelers' diarrhea? Yes – submit documentation No
- Has the Recipient tried and failed (or have a contraindication or intolerance to) at least one fluoroquinolone agent for the treatment of this condition? Yes – list agent: _____ & submit documentation No

Irritable bowel syndrome with diarrhea INITIAL requests:

- Does the Recipient have documentation of a diagnosis of irritable bowel syndrome with diarrhea?
 Yes – submit documentation No
- Has the Recipient tried and failed, or have an intolerance or contraindication to, an agent in each of the following groupings for the treatment of diarrhea (check all that apply and submit documentation)?
 Anti-diarrheals: loperamide other: _____
 Antispasmodics: dicyclomine hysocyamine (not covered by MA) other: _____
- Have other causes of chronic diarrhea been ruled out? Yes (submit documentation) No
- Has the Recipient tried & failed the standard IBS-D dietary modifications? Yes (submit documentation) No

Irritable bowel syndrome with diarrhea RENEWAL requests:

- Was the Recipient's initial treatment course successful? Yes (submit documentation) No
- Have the Recipient's symptoms of IBS-D recur since the initial treatment course? Yes (submit documentation) No
- How many previous Xifaxan treatment courses did the Recipient have*? one two three other: _____

*Submit documentation and dates of ALL previous Xifaxan treatment courses.

PLEASE FAX COMPLETED FORM WITH CLINICAL INFORMATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____ **Date:** _____

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