Please complete ALL information below and fax your request to 1-888-671-5285

Xifaxan® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Hepatic encephalopathy (HE) recurrence prophylaxis
❑ Irritable bowel syndrome with diarrhea (IBS-D)
❑ Small bowel bacterial overgrowth (SBBO)/Small intestinal bacterial overgrowth (SIBO)
❑ Travelers' diarrhea
❑ Treatment of hepatic encephalopathy (HE)
❑ Other diagnosis: ______________________________ ICD-10 Code(s): ____________________________________

Hepatic encephalopathy (HE) recurrence prophylaxis OR Treatment of hepatic encephalopathy (HE):

Is the requested medication being used as an add-on therapy to lactulose? ❑ **Yes** ❑ **No**
Is the patient unable to achieve an optimal clinical response with lactulose monotherapy? ❑ **Yes** ❑ **No**
Does the patient have a history of contraindication or intolerance to lactulose? ❑ **Yes** ❑ **No**

Irritable bowel syndrome with diarrhea (IBS-D):

Select the medications the patient has a trial and failure, contraindication, or intolerance to:

❑ Antidiarrheal agent (e.g., loperamide)
❑ Antispasmodic agent (e.g., dicyclomine, hyoscyamine)
❑ Tricyclic antidepressant (e.g., amitriptyline)

Small bowel bacterial overgrowth (SBBO)/Small intestinal bacterial overgrowth (SIBO):

Select the medications the patient has a trial and failure to:

❑ Augmentin (amoxicillin-clavulanic acid)
❑ Bactrim (trimethoprim-sulfamethoxazole)
❑ Cipro (ciprofloxacin)
❑ Flagyl (metronidazole)
❑ Keflex (cephalexin)
❑ Minocin (minocycline)
❑ Neomycin
❑ Tetracycline
❑ Vibramycin (doxycycline)

Select the medications the patient has a resistance, contraindication, or intolerance to:

❑ Augmentin (amoxicillin-clavulanic acid)
❑ Bactrim (trimethoprim-sulfamethoxazole)
❑ Cipro (ciprofloxacin)
❑ Flagyl (metronidazole)
❑ Keflex (cephalexin)
❑ Minocin (minocycline)
❑ Neomycin
❑ Tetracycline
❑ Vibramycin (doxycycline)

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Travelers' diarrhea:

Select the medications the patient has a trial and failure to:

- ❑ Cipro (ciprofloxacin)
- ❑ Levaquin (levofloxacin)
- ❑ Ofloxacin
- ❑ Zithromax (azithromycin)

Select the medications the patient has a resistance, contraindication, or intolerance to:

- ❑ Cipro (ciprofloxacin)
- ❑ Levaquin (levofloxacin)
- ❑ Ofloxacin
- ❑ Zithromax (azithromycin)

Reauthorization:

If this is a reauthorization request, please answer the following:

Irritable bowel syndrome with diarrhea (IBS-D) only:

Has the patient experienced irritable bowel syndrome with diarrhea (IBS-D) symptom recurrence? ❑ **Yes** ❑ **No**

Small bowel bacterial overgrowth (SBBO)/Small intestinal bacterial overgrowth (SIBO) only:

Is there documentation of positive clinical response to Xifaxan therapy (e.g., resolution of symptoms or relapse with Xifaxan discontinuation)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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