FUTURE SCRIPTS

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

Xifaxan® 550mg Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Hepatic disease with risk for hepatic encephalopathy (i.e. previous episode of hepatic encephalopathy, advanced liver disease, hepatocellular carcinoma)
- ❑ Irritable bowel syndrome – Diarrhea
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Hepatic disease with risk for hepatic encephalopathy:

Has the patient had an inadequate response to or inability to tolerate lactulose? ❑ **Yes** ❑ **No**

Irritable bowel syndrome – Diarrhea:

Select the medications the patient has had an inadequate response to or inability to tolerate:

- ❑ Antispasmodic
- ❑ Selective serotonin reuptake inhibitor
- ❑ Tricyclic antidepressant

Reauthorization:

If this is a reauthorization request, answer the following:

Has the patient exceeded 3 courses (42 days) of therapy in their lifetime? ❑ **Yes** ❑ **No**

Is there documentation of Xifaxan treatment within the last 10 weeks? ❑ **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?

_____

_____

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

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