



XIFAXAN

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date: _____

SECTION A - PATIENT INFORMATION

First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW or a CONTINUATION of THERAPY ? If so, start date: _____

Is this patient currently hospitalized? Yes No

SECTION B - PHYSICIAN INFORMATION

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: Zip:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax Attention to:		

Medication: _____ Strength: _____

Directions for use:

Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
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Explanation of why the preferred medication(s) would not meet your patient's needs:

If diagnosis is traveler's diarrhea:

- Does the patient have traveler's diarrhea caused by *E. coli*? (circle answer) **YES** or **NO**
- Is the patient's diarrhea complicated by fever or blood in the stool? (circle answer) **YES** or **NO**

If diagnosis is hepatic encephalopathy/cirrhosis:

- Has the patient had 2 episodes of hepatic encephalopathy associated with hepatic cirrhosis during the previous 6 months? (circle answer) **YES** or **NO**
 - Is the patient currently in remission from a hepatic encephalopathy episodes? (circle answer) **YES** or **NO**
 - What is the patients Model For End Stage Liver Disease (MELD) score? _____
 - If this is reauthorization: Has clinical benefit of the past Xifaxan therapy documented? **YES** or **NO**
- Describe benefit: _____

Other Medications Tried

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Physician Signature: _____ **Date:** _____

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