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:
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:** _____