OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

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

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Hepatic encephalopathy (HE) recurrence prophylaxis
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome with diarrhea (IBS-D)
- ❑ Other diagnosis: _____
- ❑ Small bowel bacterial overgrowth (SBBO)/Small intestinal bacterial overgrowth (SIBO)
- ❑ Travelers' diarrhea
- ❑ Treatment of hepatic encephalopathy (HE)

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**

Inflammatory Bowel Disease:

Does the patient have a history of failure, contraindication, or intolerance to Cipro (ciprofloxacin) **AND** Flagyl (metronidazole)? ❑**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)

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

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

Travelers' diarrhea:

Select the medications the patient has a <u>trial and failure</u> to:

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

Select the medications the patient has a <u>resistance, contraindication, or intolerance</u> to:

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

Reauthorization:

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

Inflammatory bowel disease only:

Is there documentation of positive clinical response to Xifaxan therapy? ❑ **Yes** ❑ **No**

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

Has the patient experienced IBS-D symptom recurrence? ❑ **Yes** ❑ **No**

If yes, was this after a prior 14 day course of therapy with Xifaxan? ❑ **Yes** ❑ **No**

Has the patient had a treatment-free period between courses of therapy? ❑ **Yes** ❑ **No**

Has the patient received 3 treatment courses of Xifaxan for IBS-D in the previous 6 months? ❑ **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**

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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

_____

_____

<u>Please note</u>: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.