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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)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)

Select the diagnosis below:

Irritable bowel syndrome with diarrhea (IBS-D)

Prophylaxis of hepatic encephalopathy (HE) recurrence

Travelers' diarrhea (TD)

Treatment of hepatic encephalopathy (HE)

Other diagnosis: _____ ICD-10 Code(s): _____

IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D):

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

Loperamide

Viberzi

Other antidiarrheal agent. Please specify: _____

Reauthorization:

If this is a reauthorization request, answer the following:

Does the patient experience irritable bowel syndrome with diarrhea (IBS-D) symptom recurrence? Yes No

PROPHYLAXIS OF HEPATIC ENCEPHALOPATHY (HE) RECURRENCE:

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

Constulose

Enulose

Generlac

Lactulose

TRAVELERS' DIARRHEA (TD):

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

<input type="checkbox"/> Azithromycin	<input type="checkbox"/> Levofloxacin
<input type="checkbox"/> Cipro	<input type="checkbox"/> Ofloxacin
<input type="checkbox"/> Ciprofloxacin	<input type="checkbox"/> Zithromax
<input type="checkbox"/> Levaquin	

Select the medications the patient has resistance to:

<input type="checkbox"/> Cipro (ciprofloxacin)	<input type="checkbox"/> Ofloxacin
<input type="checkbox"/> Levaquin (levofloxacin)	<input type="checkbox"/> Zithromax (azithromycin)

TREATMENT OF HEPATIC ENCEPHALOPATHY (HE):

Has the patient had a trial and failure, contraindication, or intolerance to lactulose? Yes No

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
Office use only: Xifaxan_CMS_2020Apr-W



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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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-844-403-1028.