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:

- ❑ 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 <u>trial and failure, contraindication, or intolerance</u> to:

- ❑ Azithromycin
- ❑ Cipro
- ❑ Ciprofloxacin
- ❑ Levaquin
- ❑ Levofloxacin
- ❑ Ofloxacin
- ❑ Zithromax

Select the medications the patient has <u>resistance</u> to:

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

TREATMENT OF HEPATIC ENCEPHALOPATHY (HE):

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

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

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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.