Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Xifaxan - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Does the patient have hypersensitivity to rifaximin, any of the rifamycin antimicrobial agents, or any component of the formulation?

☐ Yes ☐ No

Q2. Is the requested drug being prescribed by or in consultation with a Gastroenterologist, Hepatologist, or Infectious Disease specialist?

☐ Yes ☐ No

Q3. Does the patient have a confirmed diagnosis of Travelers' Diarrhea (TD) caused by noninvasive strains of Escherichia coli (E. coli) with treatment failure or inadequate response to a fluoroquinolone (e.g., ciprofloxacin, levofloxacin) or azithromycin?
If No, go to 6.

☐ Yes ☐ No

Q4. Will the dosing for Travelers' Diarrhea (TD) be 200 mg three times a day?

☐ Yes ☐ No

Q5. Is the patient 12 years of age or older?
If Yes, go to 14.

☐ Yes ☐ No

Q6. Does the patient have a diagnosis of Hepatic Encephalopathy (HE)?
Note: Attach documentation to confirm diagnosis.
If No, go to 10.

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q7. Has the patient had a trial of or inadequate response to lactulose?

☐ Yes ☐ No

Q8. Will the dosing for Hepatic Encephalopathy (HE) be 550 mg twice a day?

☐ Yes ☐ No

Q9. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q10. Does the patient have a diagnosis of Irritable Bowel Syndrome (IBS) with diarrhea?
Attach chart note/medical records to confirm diagnosis.

☐ Yes ☐ No

Q11. Has the patient had inadequate response, intolerance or contraindication to one antispasmodic agent (e.g., dicyclomine) or one anti-diarrheal agent (e.g., diphenoxylate/atropine, loperamide)?

☐ Yes ☐ No

Q12. Will the dosing for Irritable Bowel Syndrome (IBS) with diarrhea be 550 mg three times a day?

☐ Yes ☐ No

Q13. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q14. Additional Information:

Q15. Duration:

☐ 3 days for Traveler's diarrhea
☐ 14 days for IBS w/diarrhea
☐ 12 months for Hepatic Encephalopathy

Prescriber Signature

Date

2022 Medicare Prior Authorization Request