**FAX Completed Form To**
1.833.404.2392
**Prescriber Help Desk**
1.833.587.2012
**Online**
covermymeds.com/main/prior-authorization-forms/

# Request for Prior Authorization
# RIFAXIMIN (XIFAXAN®)
(PLEASE PRINT – ACCURACY IS IMPORTANT)

| IA Medicaid Member ID # | Patient name | DOB |
|---|---|---|
| Patient address | | |
| Provider NPI | Prescriber name | Phone |
| Prescriber address | | Fax |
| Pharmacy name | Address | Phone |
| **Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.** | | |
| Pharmacy NPI | Pharmacy fax | NDC |

**Prior authorization is required for rifaximin. Only FDA approved dosing will be considered. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.**

☐ Xifaxan

| Strength | Dosage Instructions | Quantity | Days Supply |
|---|---|---|---|
| | | | |

**Diagnosis (select from below):**

☐ **Travelers' Diarrhea**

**Payment will be considered under the following conditions:**

**Patient is 12 years of age or older:** ☐ Yes ☐ No

**Patient has a diagnosis of travelers' diarrhea not complicated by fever or blood in the stool or diarrhea due to pathogens other than *Escherichia coli*:** ☐ Yes ☐ No

**Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with a preferred generic fluoroquinolone or azithromycin:**

Drug name & dose:_____ Trial dates:_____

Reason for failure:_____

**A maximum 3 day course of therapy (9 tablets) of the 200mg tablets per 30 days will be allowed.**

☐ **Hepatic Encephalopathy**

**Patient is 18 years of age or older:** ☐ Yes ☐ No

**Patient has a diagnosis of hepatic encephalopathy:** ☐ Yes ☐ No

**Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with a lactulose:**

Trial dose:_____ Trial dates:_____

Reason for failure:_____

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## Request for Prior Authorization-*Continued*
## RIFAXIMIN (XIFAXAN®)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Irritable Bowel Syndrome with Diarrhea**

**Patient is 18 years of age or older:** ☐ Yes ☐ No

**Patient has a diagnosis of irritable bowel syndrome with diarrhea:** ☐ Yes ☐ No

**Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with a preferred antispasmotic agent (dicyclomine, hyoscyamine):**

Drug name & dose:_____ Trial dates:_____

Reason for failure:_____

**Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with amitriptyline and loperamide:**

Amitriptyline Trial: Dose:_____ Trial dates:_____

Reason for failure:_____

Loperamide Trial: Dose:_____ Trial dates:_____

Reason for failure:_____

**If criteria for coverage are met, a single 14-day course will be approved.**

**Subsequent requests will require documentation of recurrence of IBS-D symptoms. A minimum 10 week treatment-free period between courses is required. A maximum of 3 treatment courses of rifaximin will be allowed per lifetime.**

☐ Recurrence of IBS-D symptoms? ☐ Yes (describe):_____ ☐ No

☐ Previous treatment? ☐ Yes (provide all treatment dates):_____ ☐ No

Possible drug interactions/conflicting drug therapies:_____

***Attach lab results and other documentation as necessary.***

| Prescriber signature (Must match prescriber listed above.) | Date of submission |
|---|---|
| | |

***IMPORTANT NOTE:*** *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*