



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xifaxan

Phone: 800-728-7947

Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department 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 left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
	Supervising Physician:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Please provide ICD code(s) for diagnosis.
Q2. What diagnosis is Xifaxan being prescribed for (pick one)? ☐ Hepatic encephalopathy, prophylaxis ☐ Irritable bowel syndrome (IBS) with diarrhea ☐ Traveler's diarrhea, noninvasive strains of e. coli ☐ Other (please specify)
Q3. What regimen is being prescribed? ☐ Xifaxan 550 mg 2 times daily ☐ Xifaxan 550 mg 3 times daily ☐ Xifaxan 200 mg 3 times daily ☐ Other (specify regimen and provide citation to support use)
Q4. If prophylaxis of hepatic encephalopathy, has patient ever had encephalopathy with admission to a hospital while on lactulose? ☐ Yes ☐ No
Q5. If prophylaxis of hepatic encephalopathy, has patient ever had encephalopathy with uncontrolled diarrhea? ☐ Yes ☐ No



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xifaxan

Phone: 800-728-7947

Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department 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 left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name: Supervising Physician:
Q6. If prophylaxis of hepatic encephalopathy, has patient ever had encephalopathy with an intolerance to lactulose? £ Yes £ No	
Q7. If prophylaxis of hepatic encephalopathy, has patient ever had encephalopathy not improving with lactulose alone? £ Yes £ No	
Q8. Additional Comments:	

Prescriber Signature

Date

☐ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document