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. Please specify the quantity and days supply being requested.

Q5. Is the patient a new start to therapy?

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ Yes	☐ No

Q6. If for prophylaxis of hepatic encephalopathy, has patient ever had encephalopathy with one of the following? Please select all that apply

- ☐ Admission to hospital while on lactulose
- ☐ Clinically significant intolerance to lactulose
- ☐ No improvement with lactulose alone
- ☐ Uncontrolled diarrhea
- ☐ None of the above

Q7. 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 a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.