

# 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:	0 1. 15
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	(7, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,
Primary Phone:	Specialty/facility nam	e (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 o	ne)?	
☐ 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 req	uested.	
Q5. Is the patient a new start to therapy?		



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	Prescriber Name:
Patient Name:	Supervising Physician:
Yes	□No
Q6. If for prophylaxis of hepatic encephalopathy, has patiently Please select all that apply	ent ever had encephalopathy with one of the following?
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/Orgent - By checking this box and signing above  seriously jeopardize the life or health of the enrollee or the organization.  The seriously jeopardize the life or health of the enrollee or the organization.  The seriously jeopardize the life or health of the enrollee or the organization.  The seriously jeopardize the life or health of the enrollee or the organization.  The seriously jeopardize the life or health of the enrollee or the organization.  The seriously jeopardize the life or health of the enrollee or the organization.  The seriously jeopardize the life or health of the enrollee or the organization.  The seriously jeopardize the life or health of the enrollee or the organization.  The seriously jeopardize the life or health of the enrollee or the organization.  The seriously jeopardize the life or health of the enrollee or the organization.  The seriously jeopardize is the life or health of the enrollee or the organization.  The seriously jeopardize is the life or health of the enrollee or the organization.  The seriously jeopardize is the life or health or the organization.  The seriously jeopardize is the life or health or the life or health or the organization or the life or the life or health	ve, I certify that applying the standard review timeframe may enrollee's ability to regain maximum function
	essity denial. Requesting providers may speak to a SWHP pharmacist an opportunity to help impact the decision on a request before coverage

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