PRO ACT PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Xifaxan® Prior Authorization Request Form (Page 1 of 3)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
- ❑ Hepatic encephalopathy (HE) recurrence prophylaxis
- ❑ Irritable bowel syndrome with diarrhea (IBS-D)
- ❑ Small bowel bacterial overgrowth (SBBO)
- ❑ Travelers' diarrhea
- ❑ Other diagnosis:_____ICD-10 Code(s): _____

Hepatic encephalopathy (HE) recurrence prophylaxis:

Does the patient have a history of failure, contraindication, or intolerance to lactulose? ❑ **Yes** ❑ **No**

Irritable bowel syndrome with diarrhea (IBS-D):

Select the medications the patient has a failure, contraindication, or intolerance to:
- ❑ Antidiarrheal agent (e.g., loperamide)
- ❑ Antispasmodic (e.g., dicyclomine, hyoscyamine)
- ❑ Tricyclic antidepressant (e.g., amitriptyline)

Small bowel bacterial overgrowth (SBBO):

Select the medications the patient has a <u>failure</u> to:
- ❑ Augmentin (amoxicillin-clavulanic acid)
- ❑ Bactrim (trimethoprim-sulfamethoxazole)
- ❑ Cipro (ciprofloxacin)
- ❑ Flagyl (metronidazole)
- ❑ Minocin (minocycline)
- ❑ Neomycin
- ❑ Tetracycline
- ❑ Vibramycin (doxycycline)

Select the medications the patient has a <u>resistance, contraindication, or intolerance</u> to:
- ❑ Augmentin (amoxicillin-clavulanic acid)
- ❑ Bactrim (trimethoprim-sulfamethoxazole)
- ❑ Cipro (ciprofloxacin)
- ❑ Flagyl (metronidazole)
- ❑ Minocin (minocycline)
- ❑ Neomycin
- ❑ Tetracycline
- ❑ Vibramycin (doxycycline)

PRO ACT PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Xifaxan® Prior Authorization Request Form (Page 2 of 3)

Travelers' diarrhea:

Select the medications the patient has a failure to:

- ❑ Cipro (ciprofloxacin)
- ❑ Levaquin (levofloxacin)
- ❑ Ofloxacin
- ❑ Zithromax (azithromycin)

Select the medications the patient has a resistance, contraindication, or intolerance to:

- ❑ Cipro (ciprofloxacin)
- ❑ Levaquin (levofloxacin)
- ❑ Ofloxacin
- ❑ Zithromax (azithromycin)

Reauthorization:

If this is a reauthorization request, please answer the following:

Irritable bowel syndrome with diarrhea (IBS-D) only:

Has the patient experienced IBS-D symptom recurrence? ❑ **Yes** ❑ **No**

Has the patient already received 3 treatment courses of Xifaxan for IBS-D in their lifetime? ❑ **Yes** ❑ **No**

Small bowel bacterial overgrowth (SBBO) only:

Is there documentation of positive clinical response to Xifaxan therapy (e.g., resolution of symptoms or relapse with Xifaxan discontinuation)? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Xifaxan® Prior Authorization Request Form (Page 3 of 3)

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	