PRIOR AUTHORIZATION REQUEST FORM

BMCHP Antibiotics (Systemic) - Policy 9.108 (2)
Xifaxan

Phone: 888-566-0008 **Fax back to: 866-414-3453**

ENVISION RX OPTIONS 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:**	
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):	

☐ Expedited/Urgent

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. Is the request for initial or continuing therapy?

☐ Initial therapy (Start date MM/YY):
☐ Continuing therapy

Q2. Please specify the medication requested:

☐ Xifaxan 200 mg Tablets
☐ Xifaxan 550 mg Tablets

Q3. Please indicate the diagnosis below:

☐ Traveler's Diarrhea caused by non-invasive strains of E. coli
☐ Hepatic Encephalopathy
☐ Diarrhea predominant irritable bowel syndrome (IBS) with bloating
☐ Other (please specify):

Q4. Please indicate the medication(s) tried and failed, experienced intolerance, contraindication to, or resistance to. Please specify all drug names and describe the inadequate response, intolerance, or contraindication to treatment for each one below:

☐ Ciprofloxacin, please specify: _____
☐ Azithromycin, please specify: _____
☐ Lactulose, please specify: _____

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Patient Name: **Prescriber Name:**

☐ Antispasmodic: _____, please specify: _____
☐ Tricyclic antidepressant:_____, please specify:_____
☐ Dietary changes such as restriction of lactose, fructose, gas-producing foods, or caffeine, please specify:

Q5. Is the patient 18 years or older?
☐ Yes ☐ No

Q6. Please provide any supporting clinical statements (e.g. chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request

Prescriber Signature

Date