## Health Partners •••• Medicare

## PRIOR AUTHORIZATION REQUEST FORM

Xifaxan - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans 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.

Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):
☐ REQUEST FOR EXPEDITED REVIEW: By checking this the life or health of the enrollee or the enrollee's ability t	box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize o regain maximum function.
Drug Name:	
Strength: Directions / SIG:	
Directions / Sig.	
Please attach any pertinent medical hi	istory including labs and information for this member that may support approval.
	ease answer the following questions and sign.
Q1. Does the patient have hypersensiting the formulation?	vity to rifaximin, any of the rifamycin antimicrobial agents, or any component of
Yes	□ No
Q2. Is the requested drug being prescri Disease specialist?	bed by or in consultation with a Gastroenterologist, Hepatologist, or Infectious
Yes	□ No
	diagnosis of Travelers' Diarrhea (TD) caused by noninvasive strains of failure or inadequate response to a fluoroquinolone (e.g., ciprofloxacin, to 6.
Yes	□ No
Q4. Will the dosing for Travelers' Diarrh	nea (TD) be 200 mg three times a day?
Yes	□ No
Q5. Is the patient 12 years of age or old	der?
Yes	□ No
Q6. Does the patient have a diagnosis diagnosis. If No, go to 10.	of Hepatic Encephalopathy (HE)? Please attach documentation to confirm
☐Yes	□ No
Q7. Has the patient had a trial of or inac	dequate response to lactulose?

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

## Health Partners •••• Medicare

## PRIOR AUTHORIZATION REQUEST FORM

Xifaxan - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:	
Yes	□ No	
Q8. Will the dosing for Hepatic Encephalopathy (HE) be 550 mg twice a day?		
☐ Yes	□ No	
Q9. Is the patient 18 years of age or older?		
☐ Yes	□No	
Q10. Does the patient have a diagnosis of Irritable Bowel Syndrome (IBS) with diarrhea? Attach chart note/medical records to confirm diagnosis.		
☐ Yes	□ No	
Q11. Has the patient had inadequate response, intolerance or contraindication to one antispasmodic agent (e.g., dicyclomine) or one anti-diarrheal agent (e.g., diphenoxylate/atropine, loperamide)?		
☐ Yes	□ No	
Q12. Will the dosing for Irritable Bowel Syndrome (IBS) with diarrhea be 550 mg three times a day?		
☐ Yes	□ No	
Q13. Is the patient 18 years of age or older?		
☐ Yes	□ No	
Q14. Additional Information:		
Q15. Duration:		
3 days for Traveler's diarrhea		
☐ 14 days for IBS w/diarrhea☐ 12 months for Hepatic Encephalopathy		
Other		
Prescriber Signature		
i lescriber dignature	2023 Medicare Prior Authorization Request	

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