PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Xifaxan Aemcolo - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Xifaxan Aemcolo - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Aemcolo (rifamycin) Xifaxan (rifaximin)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have an allergy to Xifaxan or Aemcolo or any of their components? Y N

[If yes, then no further questions.]

2. Is this request for Xifaxan 550mg? Y N

[If no, then skip to question 13.]

3. Does the patient have the documented diagnosis of hepatic encephalopathy? Y N _____

[Note: Documentation must be submitted.]

[If no, then skip to question 6.]	
4. Is the patient 18 years of age or older?	Y N
[If no, then no further questions.]	
5. Does the patient have a documented trial and inadequate response to lactulose?	Y N
[Note: Documentation must be submitted.]	
[No further questions.]	
6. Does the patient have the documented diagnosis of diarrhea-predominant Irritable Bowel Syndrome (IBS)?	Y N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
7. Is the patient 18 years of age or older?	Y N
[If no, then no further questions.]	
8. Has the patient previously received treatment with the requested drug?	Y N
[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]	
[If no, then skip to question 11.]	
9. Is the patient experiencing a documented recurrence of symptoms?	Y N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
10. Has the patient already received an initial 14-day course of treatment AND two additional 14-day courses of treatment with the requested drug?	Y N
[No further questions.]	
11. Does the patient have a documented trial and inadequate response to antispasmodic therapy (dicyclomine or hyoscyamine)?	Y N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
12. Does the patient have a documented trial and inadequate response to an additional formulary alternative?	Y N
[Note: Documentation must be submitted.]	
[No further questions.]	
13. Is this request for Xifaxan 200mg?	Y N
[If no, then skip to question 19.]	
14. Does the patient have the documented diagnosis of traveler's diarrhea caused by non-invasive Escherichia coli (E.coli)?	Y N
[Note: Documentation must be submitted.]	

[If no, then no further questions.]	
15. Is the patient 12 years of age or older?	Y N
[If no, then no further questions.]	
16. Is the patient returning from an area of high fluoroquinolone resistance?	Y N
[If no, then skip to question 18.]	
17. Does the patient have a documented trial and failure of azithromycin?	Y N
[Note: Documentation must be submitted.]	
[No further questions.]	
18. Does the patient have a documented treatment failure or intolerance to a fluoroquinolone?	Y N
[Note: Documentation must be submitted.]	
[No further questions.]	
19. Does the patient have the documented diagnosis of traveler's diarrhea caused by non-invasive Escherichia coli (E.coli)?	Y N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
20. Is the patient 18 years of age or older?	Y N
[If no, then no further questions.]	
21. Is the patient returning from an area of high fluoroquinolone resistance?	Y N
[If no, then skip to question 23.]	
22. Does the patient have a documented trial and failure of azithromycin?	Y N
[Note: Documentation must be submitted.]	
[No further questions.]	
23. Does the patient have a documented treatment failure or intolerance to a fluoroquinolone?	Y N
[Note: Documentation must be submitted.]	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date