Prior Authorization Request Form for

rifaximin (Xifaxan) 200mg

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. Is the use for treatment of traveler's diarrhea caused by noninvasive strains of E. coli?	☐ Yes Proceed to Question **2**	☐ No **STOP** Coverage not approved
2. Is the patient 12 years of age or older?	☐ Yes Proceed to Question **3**	☐ No **STOP** Coverage not approved
3. Does the patient have diarrhea complicated by fever or bloody stool?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to Question **4**
4. Does the patient have diarrhea due to pathogens other than noninvasive strains of *E. coli*?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to Question **5**
5. Has the patient tried and failed a 3-day trial of ciprofloxacin or is ciprofloxacin contraindicated?	☐ Yes **Sign and date below**	☐ No Proceed to Question **6**
6. Has the patient tried and failed azithromycin or is azithromycin contraindicated?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

† Coverage is NOT provided for the treatment of other conditions not listed above, including: diarrhea complicated by fever or bloody stool, dysentery, diarrhea associated with use of antibiotics, diarrhea caused by bacteria other than E. coli, C. difficile infection, irritable bowel syndrome, inflammatory bowel disease, chronic abdominal pain, hepatitis, diabetes, rosacea, or any other non-FDA approved use.

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Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[12 June 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: