

Prior Authorization Request Form for rifaximin (Xifaxan) 550 mg



JOHNS HOPKINS
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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

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 patient greater than or equal to 18 years old?	<input type="checkbox"/> Yes proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Will this medication be used for treatment of hepatic encephalopathy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No proceed to question 3
3. Does the patient have a diagnosis of IBS-diarrhea type, without constipation, and have symptoms of moderate abdominal pain and bloating?	<input type="checkbox"/> Yes proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Is the prescription written by or in consultation with a gastroenterologist?	<input type="checkbox"/> Yes proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Is there documentation that the patient has failure of dietary changes (including fiber), stress reduction, or cognitive behavioral therapy?	<input type="checkbox"/> Yes proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Has the patient had a failure, intolerance, or contraindication to at least one antispasmodic/antidiarrheal agent (for example, dicyclomine [Bentyl], Librax, hyoscyamine [Levsin], Donnatal, loperamide [Imodium])?	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved

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7. Has the patient had a failure, intolerance, or contraindication to at least one tricyclic antidepressant (that is, to relieve abdominal pain) (for example, amitriptyline, desipramine, doxepin, imipramine, nortriptyline, protriptyline)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
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† Coverage is NOT provided for the treatment of other conditions not listed above, including: small intestinal bacterial overgrowth (SIBO), non-alcoholic steatohepatitis (NASH) or non-alcoholic fatty liver disease (NAFLD), spontaneous bacterial peritonitis (SBP), functional dyspepsia, diabetes, cirrhosis (ascites/alcohol-related), graft vs host disease, primary sclerosing cholangitis, Celiac disease, ulcerative colitis, Crohn's disease, diverticular disease, bowel preparation, constipation, colorectal cancer prevention, opioid-induced constipation, chronic abdominal pain, or other disease states.

•Prior authorization for rifaximin for IBS-D expires every 12 months **AND** only up to 3 courses will be authorized during a 12 month period.

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

Prescriber Signature Date

[15 May 2019]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: _____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: