



Prior Authorization
<p>JOHNS HOPKINS HEALTHCARE (MEDICAID) Xifaxan Aemcolo - Priority Partners MCO</p> <p>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 Healthcare at 1-410-424-4607. Please contact Johns Hopkins Healthcare at 1-888-819-1043 with questions regarding the Prior Authorization process.</p> <p>When conditions are met, we will authorize the coverage of Xifaxan Aemcolo - Priority Partners MCO.</p>

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: _____
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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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, then no further questions.]	
2. Is this request for Xifaxan 550mg?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then skip to question 13.]	
3. Does the patient have the documented diagnosis of hepatic encephalopathy?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	

[If no, then skip to question 6.]	
4. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
5. Does the patient have a documented trial and inadequate response to lactulose?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[No further questions.]	
6. Does the patient have the documented diagnosis of diarrhea-predominant Irritable Bowel Syndrome (IBS)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
7. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
8. Has the patient previously received treatment with the requested drug?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
11. Does the patient have a documented trial and inadequate response to antispasmodic therapy (dicyclomine or hyoscyamine)?	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[No further questions.]	
13. Is this request for Xifaxan 200mg?	<input type="checkbox"/> Y <input type="checkbox"/> 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)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	

[If no, then no further questions.]	
15. Is the patient 12 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
16. Is the patient returning from an area of high fluoroquinolone resistance?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then skip to question 18.]	
17. Does the patient have a documented trial and failure of azithromycin?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[No further questions.]	
18. Does the patient have a documented treatment failure or intolerance to a fluoroquinolone?	<input type="checkbox"/> Y <input type="checkbox"/> 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)?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[If no, then no further questions.]	
20. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then no further questions.]	
21. Is the patient returning from an area of high fluoroquinolone resistance?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, then skip to question 23.]	
22. Does the patient have a documented trial and failure of azithromycin?	<input type="checkbox"/> Y <input type="checkbox"/> N
[Note: Documentation must be submitted.]	
[No further questions.]	
23. Does the patient have a documented treatment failure or intolerance to a fluoroquinolone?	<input type="checkbox"/> Y <input type="checkbox"/> 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