OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
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Xifaxan® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP:	Office Street Address:		
Phone:			City:	State:	ZIP:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
	Directions for Use:	

Clinical Information (required)	
1. Does the patient have a diagnosis of travelers' diarrhea?	❑ Yes ❑ No
2. Has the patient had a trial and failure of ONE of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), Ofloxacin or Zithromax (azithromycin)?	❑ Yes ❑ No
3. Does the patient have resistance, contraindication or intolerance to ALL of the following antibiotics: Cipro (ciprofloxacin), Levaquin (levofloxacin), Ofloxacin and Zithromax (azithromycin)?	❑ Yes ❑ No
4. Does the patient have a diagnosis of small bowel bacterial overgrowth/small intestinal bacterial overgrowth?	❑ Yes ❑ No
5. Has the patient had a trial and failure of TWO of the following antibiotics? • Augmentin (amoxicillin/clavulanic acid) • Bactrim (trimethoprim-sulfamethoxazole) • Cipro (ciprofloxacin) • Flagyl (metronidazole) • Keflex (cephalexin) • Neomycin • Vibramycin (doxycycline) or Minocin (minocycline) or tetracycline	❑ Yes ❑ No
6. Does the patient have resistance, contraindication or intolerance to ALL of the following antibiotics? • Augmentin (amoxicillin/clavulanic acid) • Bactrim (trimethoprim-sulfamethoxazole) • Cipro (ciprofloxacin) • Flagyl (metronidazole) • Keflex (cephalexin) • Neomycin • Vibramycin (doxycycline) or Minocin (minocycline) or tetracycline	❑ Yes ❑ No
7. For reauthorization requests, is there documentation of positive clinical response to Xifaxan therapy (e.g., resolution of symptoms or relapse with Xifaxan discontinuation)?	❑ Yes ❑ No
8. Does the patient have a diagnosis of irritable bowel syndrome with diarrhea?	❑ Yes ❑ No
9. Has the patient had a trial and failure, contraindication or intolerance to ONE of the following: Antidiarrheal agent (e.g., loperamide), antispasmodic agent (e.g., dicyclomine, hyoscyamine) or tricyclic antidepressant (amitriptyline)?	❑ Yes ❑ No
10. For reauthorization requests, has the patient experienced irritable bowel syndrome with diarrhea symptom recurrence?	❑ Yes ❑ No
11. Is Xifaxan being used for prophylaxis of hepatic encephalopathy recurrence?	❑ Yes ❑ No
12. Is Xifaxan being used as add-on therapy to lactulose?	❑ Yes ❑ No

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13. Was the patient able to achieve an optimal clinical response with lactulose monotherapy?	❑ Yes ❑ No
14. Does the patient have a history of contraindication or intolerance to lactulose?	❑ Yes ❑ No
15. Is Xifaxan being used for the treatment of hepatic encephalopathy?	❑ Yes ❑ No
16. Is Xifaxan being used as add-on therapy to lactulose?	❑ Yes ❑ No
17. Was the patient able to achieve an optimal clinical response with lactulose monotherapy?	❑ Yes ❑ No
18. Does the patient have a history of contraindication or intolerance to lactulose?	❑ Yes ❑ No

Information on this form is accurate as of this date.

Prescriber's Signature:	**Date:**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: **This request may be denied unless all required information is received.**
For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern