REALRx

PRIOR AUTHORIZATION REQUEST FORM
XIFAXAN®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Xifaxan® (rifaximin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
HEPATIC ENCEPHALOPATHY			
2. Is the request for Hepatic Encephalopathy?	☐	☐	**Please provide documentation**
3. Is the member 18 years of age or older?	☐	☐	
4. Is the member currently using or severely intolerant to lactulose?	☐	☐	**Please provide documentation**
IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D)			
1. Does the member have IBS-D with recurrent abdominal pain for at least 1 day/week in the last 3 months?	☐	☐	**Please provide documentation**
2. Is the abdominal pain associated with at least two of the following: related to defecation, associated with a change in frequency of stool, associated with a change in form/appearance of stool?	☐	☐	**Please provide documentation**
3. Is the prescriber a gastroenterologist?	☐	☐	
4. Has the member shown trial and failure to nutritional and/or behavioral modifications (lactose restricted diet, gluten-free diet, low carb diet, elimination of fermentable oligo-di-	☐	☐	**Please provide documentation**

monosaccharides and polyols (FODMAPS), increased physical activity)?			
5. Has the member shown trial and failure or contraindication to an antidiarrheal (loperamide, diphenoxylate)?	☐	☐	**Please provide documentation**
6. Has the member shown trial and failure or contraindication/intolerance to a tricyclic antidepressant (imipramine, despiramine)?	☐	☐	**Please provide documentation**
7. Has serologic testing been performed to rule out celiac disease?	☐	☐	**Please provide documentation**
8. Does documentation show that fecal calprotectin and C-reactive protein have been checked to rule out inflammatory bowel disease?	☐	☐	**Please provide documentation**
TRAVELER'S DIARRHEA			
1. Is the request for Traveler's Diarrhea?	☐	☐	**Please provide documentation**
2. Is the member 12 years of age or older?	☐	☐	
3. Is E. coli the suspected pathogen?	☐	☐	**Please provide documentation**
4. Has the member shown trial and failure or contraindication to a quinolone (e.g., ciprofloxacin, levofloxacin, ofloxacin)?	☐	☐	**Please provide documentation**
SMALL INTESTINAL BACTERIAL OVERGROWTH (SIBO)			
1. Is the medication prescribed by, or in consultation with, a gastroenterologist?	☐	☐	**Please provide documentation**
2. Does the member have a documented clinical diagnosis of symptomatic (bloating, flatulence, abdominal discomfort, chronic diarrhea) SIBO by one of the following: • Glucose or lactulose breath testing • Duodenal culture resulting in colony count ≥ 10^3 CFU/mL	☐	☐	**Please provide documentation**
3. Has the member show an inadequate clinical response to at least TWO of the following antibiotic treatment regimens or contraindication to all: • Ciprofloxacin • Metronidazole • Amoxicillin-clavulanic acid • Trimethoprim-sulfamethoxazole • Doxycycline or tetracycline	☐	☐	**Please provide documentation**
4. Has the member shown an Inadequate clinical response to diet modifications (low carbohydrate diet, low fermentable oligosaccharides/disaccharides/monosaccharides/and polyols (FODMAP) diet)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. If the request is for reauthorization of therapy for treatment of hepatic encephalopathy, does updated documentation show a positive clinical response from therapy, such as a decrease in fasting serum ammonia levels and mental status?	☐	☐	**Please provide documentation**
2. If the request is for reauthorization of therapy for IBS-D, is the member responding to treatment?	☐	☐	**Please provide documentation**
3. If the request is for reauthorization of therapy for traveler's diarrhea, did the member have improved symptoms after 24-48 hours of therapy? *Please note that there is a limit of three 14-day treatment courses.*	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician's Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM- 078
Origination Date: 08/30/2017
Reviewed/Revised Date: 02/17/2023
Next Review Date: 02/17/2024
Current Effective Date: 03/01/2023