HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
XIFAXAN®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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
HEPATIC ENCEPHALOPATHY			
1. Is the request for Hepatic Encephalopathy?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or older?	☐	☐	
3. 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-monosaccharides and polyols (FODMAPS), increased physical activity)?	☐	☐	**Please provide documentation**
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 to an antispasmodic agent (dicyclomine, hyocyamine)?	☐	☐	**Please provide documentation**
7. Has the member shown trial and failure or is contraindication to a tricyclic antidepressants (imipramine, despiramine)?	☐	☐	**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**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy for hepatic encephalopathy?	☐	☐	
2. 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**
3. Is the request for reauthorization of therapy for IBS-D?	☐	☐	
4. Does documentation show that the member responded to treatment?	☐	☐	**Please provide documentation**
5. Is the request for reauthorization of therapy for traveler's diarrhea? *Please note that there is a limit of three 14-day treatment courses.*	☐	☐	
6. Did the member have improved symptoms after 24-48 hours of therapy?	☐	☐	**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:

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Policy PHARM- 078
Origination Date: 08/30/2017
Reviewed/Revised Date: 03/25/2020
Next Review Date: 03/25/2021
Current Effective Date: 06/28/2020