Prior Authorization Form

CAREFIRST

Xifaxan 550mg

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-582-2022** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Xifaxan 550mg.

Drug Name (select from list of drugs shown)
Xifaxan 550mg (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:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is the requested drug being prescribed to reduce the risk of overt hepatic encephalopathy (HE) recurrence?	Y N
	[If no, then skip to question 3.]	
2.	Is the requested drug being used as add-on therapy to lactulose?	Y N
	[No further questions.]	
3.	Does the patient have the diagnosis of irritable bowel syndrome with diarrhea (IBS-D)?	Y N
	[If no, then no further questions.]	

4.	Has the patient previously received treatment with the requested drug?	Y N
	[If no, then no further questions.]	
5.	Is the patient experiencing a recurrence of symptoms?	Y N
	[If no, then no further questions.]	
6.	Has the patient already received an initial 14-day course of treatment AND two additional 14-day courses of treatment with the requested drug?	Y N

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