OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Xifaxan® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Hepatic encephalopathy
❑ Treatment of abdominal pain and bloating in moderate to severe irritable bowel syndrome without constipation
❑ Treatment of at least a second recurrence of C. difficile
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Are there contraindications or absolute drug interactions with existing therapy? ❑ **Yes** ❑ **No**

Hepatic encephalopathy:

Has the patient had a prior trial and failure of lactulose? ❑ **Yes** ❑ **No**
Is this a continuation of prior therapy? ❑ **Yes** ❑ **No**
If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: (**REQUIRED)**

_____
_____

Treatment of abdominal pain and bloating in moderate to severe irritable bowel syndrome without constipation:

Has the patient had prior trial and failure with TWO different tricyclic antidepressants: Amitriptyline, desipramine, imipramine, nortriptyline? ❑ **Yes** ❑ **No**
Has the patient had treatment failure with TWO different antispasmodics: Dicyclomine and hyoscyamine? ❑ **Yes** ❑ **No**
Is the patient following a low FODMAP diet? ❑ **Yes** ❑ **No**

Treatment of at least a second recurrence of C. difficile:

Is Xifaxan being used following a course of treatment with vancomycin? ❑ **Yes** ❑ **No**
Has the patient had treatment failure with TWO of the following: Dificid, metronidazole, oral vancomycin? ❑ **Yes** ❑ **No**

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 urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

Office use only: Xifaxan_GoldCoast_2018Aug-W