



Xifaxan (Rifaximin)
Prior Authorization Request Form
 Caterpillar Prescription Drug Benefit
 Phone: 877-228-7909 Fax: 800-424-7640



Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
 AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:	
NPI NUMBER:	DEA NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page





Xifaxan (Rifaximin)
Prior Authorization Request Form



Caterpillar Prescription Drug Benefit
 Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES: <input type="checkbox"/> C. difficile colitis <input type="checkbox"/> Hepatic encephalopathy <input type="checkbox"/> Diarrhea-predominant Irritable bowel syndrome(IBS-D) <input type="checkbox"/> Intestinal bacterial overgrowth(IBO) <input type="checkbox"/> Travelers' diarrhea <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____		ICD-10:
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
<p><u>C. difficile colitis:</u> Was the diagnosis confirmed by the patient's lab results showing that the toxin is present? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p><u>Hepatic encephalopathy:</u> Has the patient failed a trial of lactulose? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will Xifaxan be used in combination with lactulose? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a medical contraindication to lactulose? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes to the above, please submit documentation.</i></p>		
<p><u>Irritable bowel syndrome with diarrhea (IBS-D):</u> Has the patient been previously treated with Xifaxan for IBS-D in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is Xifaxan being used for the treatment of intestinal bacterial overgrowth (IBO)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?</p> <hr/> <hr/>		
<p>Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.</p>		





Xifaxan (Rifaximin)
Prior Authorization Request Form
 Caterpillar Prescription Drug Benefit
 Phone: 877-228-7909 Fax: 800-424-7640



MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
 4801 E. Washington Street, Phoenix, AZ 85034
 Phone: 877-228-7909

