Prior Authorization Request Form for Xifaxan

FAX this completed form to (877) 386-4695

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day & Duration:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Does the member have a history of contraindication to the prescribed medication?	☐ Yes ☐ No	*Submit documentation.*
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred GI and Related Antibiotics? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No	*Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

TRAVELERS' DIARRHEA:

☐ History of therapeutic failure, contraindication or intolerance to Azithromycin (start date and end date):_____

HEPATIC ENCEPHALOPATHY:

☐ History of therapeutic failure, contraindication or intolerance to Lactulose: _____

IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D):

☐ Prescribed by or in consultation with a gastroenterologist
☐ Other etiologies for chronic diarrhea have been ruled out
☐ Documented history of therapeutic failure to ALL the following:
  ☐ Lactulose, Gluten and Artificial Sweetener Avoidance:_____
  ☐ A low fermentable olgio-, di-, and monosaccharides and polyols (FODMAP) diet:_____
☐ Documented history of therapeutic failure, contraindication or intolerance to ALL the following: (medication, start date and end date)
  ☐ Loperamide:_____
  ☐ Bile Acid Sequestrant:_____

IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D) RENEWAL REQUESTS:

☐ Member has experienced a successful initial treatment course
☐ Member has documented recurrence of IBS-D symptoms
☐ Member has not received 3 treatment courses with Xifaxan in lifetime

HEPATIC ENCEPHALOPATHY RENEWAL REQUESTS:

☐ Member has experienced a positive clinical response since starting Xifaxan evidenced by:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)