UnitedHealthcare
Community Plan

Xifaxan
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328.** If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: ______________

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _______________

Section B - Provider Information

First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
NPI #:	Phone:	Fax:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No **If yes, what is this member's due date? _______________**

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- What is the patient's diagnosis? (check which applies)

□ Traveler's Diarrhea
□ Hepatic encephalopathy
□ Irritable bowel syndrome with diarrhea (IBS-D)
□ Inflammatory bowel disease (e.g. Crohn's disease, ulcerative colitis, diverticulitis)
□ Other. List diagnosis: ____

Requests for TRAVELER'S DIARRHEA:

- Does the patient have a history of failure, contraindication, or intolerance to any of the following: □ Yes □ No (check all that applies)

□ Azithromycin **□ Ciprofloxacin**
□ Levofloxacin **□ Ofloxacin**

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Has the patient received this medication previously for this diagnosis? □ Yes □ No
If yes, list last treatment date: ____________________

Requests for HEPATIC ENCEPHALOPATHY:

- Does the patient have a history of failure, contraindication, or intolerance to lactulose? □ Yes □ No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

Requests for IBS-D:

- Does the patient have a history of failure, contraindication, or intolerance to two of the following: □ Yes □ No

□ Antispasmodic agent [e.g. Bentyl (dicyclomine)]
□ Antidiarrheal agent (e.g. loperamide)
□ Tricyclic antidepressant (amitriptyline)

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Does the patient continue to need Xifaxan and has experienced positive results with prior use: □ Yes □ No
If yes, list positive results: ____
____

Requests for INFLAMMATORY BOWEL DISEASE:

- Does the patient have a history of failure, contraindication, or intolerance to both of the following: □ Yes □ No

□ Cipro (ciprofloxacin)
□ Flagyl (metronidazole)

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Does the patient have a documented positive clinical response to Xifaxan therapy? □ Yes □ No
If yes, list response: ____
____

Provider Signature: ______________________________________ **Date:** __________________

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