Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Xifaxan (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Xifaxan (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Xifaxan 200mg (rifaximin) Xifaxan 550mg (rifaximin)

Other, please specify_____

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: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Is this request for Xifaxan 200mg? Y N

   [If no, then skip to question 5.]

2. Is the requested drug being prescribed for treatment of traveler's diarrhea? Y N

3. Has the patient had an inadequate response, intolerable side effects, or a contraindication to a fluoroquinolone (e.g., ciprofloxacin, levofloxacin, norfloxacin, ofloxacin)? Y N

   If yes, please list agent tried:

   _____

[If no, then no further questions.]

4. Is the patient 12 years of age or older? Y N

   [No further questions.]

5. Is this request for Xifaxan 550mg? Y N

6. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 10.]

7. Is this request for treatment of hepatic encephalopathy (HE) AND has the patient had decreased HE symptoms or ammonium levels? Y N

   [If yes, then no further questions.]

8. Is this request for treatment of irritable bowel syndrome with diarrhea (IBS-D) and has the patient had symptom resolution during the previous treatment course? Y N

9. Has the patient received 3 treatment courses in the past year? Y N

   [No further questions.]

10. Is the patient 18 years of age or older? Y N

11. Is the requested drug being prescribed for treatment of irritable bowel syndrome with diarrhea (IBS-D)? Y N

    [If no, then skip to question 13.]

12. Has the patient had an inadequate response or intolerable side effects to 2 of the following agents: A) loperamide, B) cholestyramine or colestipol, C) antispasmodics (e.g. dicyclomine, hyoscyamine), D) tricyclic antidepressants (e.g. amitriptyline, nortriptyline)? Y N

    If yes, please list the agents tried:

    _____

    [No further questions.]

13. Is the requested drug being prescribed for treatment of hepatic encephalopathy (HE)? Y N

14. Has the patient had intolerable side effects to lactulose? Y N

    [If yes, then no further questions.]

15. Has the patient had an inadequate response with lactulose and will continue use with lactulose when Xifaxan is started? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date