AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Xifaxan® (rifaximin)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Provider Please Note: Xifaxan is NOT approved by the United States Food and Drug Administration (FDA) for the treatment of Small Intestinal Bacterial Overgrowth (SIBO)

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Diagnosis:	❑ **Hepatic Encephalopathy**	❑ **Irritable bowel syndrome with Diarrhea**	❑ **Traveler's Diarrhea**
Trial and Failure:	❑ Lactulose - 20 to 30 g (30 to 45 mL) 3 to 4 times daily	❑ History of failure, contraindication or intolerance to **THREE (3)** of the following **(verified by pharmacy paid claims; please submit chart notes to confirm treatment failure or intolerance):** ❑ Antispasmodic agent (e.g., dicyclomine) ❑ Antidiarrheal agent (e.g., diphenoxylate/atropine) ❑ Tricyclic antidepressant (e.g., amitriptyline) ❑ Dietary Changes (e.g., low FODMAP diet, fiber supplementation, gluten-free diet)	
Dose:	❑ 550 mg BID daily ❑ 400 mg TID	❑ 550 mg TID for 14 days only	❑ 200 mg TID for 3 days only
Re-Auth:		❑ Another 14 days only. Has 4 months elapsed since last Xifaxan® dose?	❑ Last dose: _____ Approval will be for 3 days only

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee:** 2/18/2016
REVISED/UPDATED/REFORMATTED: ~~5/9/2016; 5/27/2016; 8/12/2016; 12/20/2016; 8/21/2017; 6/18/2019; 9/14/2021; 10/8/2021; 6/3/2022; 6/17/2022 10/27/2023;~~ **5/9/2024**;