P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth℠

PREAUTHORIZATION FORM

Xifaxan®
(rifaximin)

Therapeutic use: Reduce the risk of overt hepatic encephalopathy recurrence
Quantity Limit:

- Hepatic encephalopathy (550 mg tablets only) – Covered at Tier 2
  - Limit of 60 tablets per month
- Investigational use (200 mg tablets only) – Covered at Tier 3
  - IBS: limit of 60 tablets per month
  - SIBO: limit of 56 tablets per month
  - *C. difficile* infection: limit of 84 tablets per month

Authorization Period: 12 months

Patient's name _____

Patient's ID# ☐☐☐ ☐☐ ☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐ ☐☐ ☐☐☐ ☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐) ☐☐☐-☐☐☐☐ Fax# ☐☐☐-☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:			
1.	Is the prescribing physician a gastroenterologist?	❑ Yes	❑ No
2.	Has the patient been diagnosed with hepatic encephalopathy?	❑ Yes	❑ No
2a.	Has the patient failed or is intolerant to lactulose therapy?	❑ Yes	❑ No
3.	Has the patient been diagnosed with irritable bowel syndrome (diarrhea or mixed type) and failed one antispasmodic treatment and one antibiotic treatment? List failed antispasmodic treatments:_____ List failed antibiotic treatments:_____	❑ Yes	❑ No
4.	Has the patient been diagnosed with small intestinal bacterial overgrowth and failed two or more antibiotic treatments? List failed antibiotic treatments:_____	❑ Yes	❑ No
5.	If intended for *Clostridium difficile* infection, has the patient experienced relapse after at least 3 other treatments? List failed antibiotic treatments:_____	❑ Yes	❑ No

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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