

Prescriber Criteria Form

Xifaxan 550mg 2025 PA Fax 1480-A v2 010125.docx  
 Xifaxan 550mg Only (rifaximin)  
 Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Xifaxan 550mg Only (rifaximin).

Drug Name:  
 Xifaxan 550mg Only (rifaximin)

<b>Patient Name:</b>		
<b>Patient ID:</b>		
<b>Patient DOB:</b>	<b>Patient Phone:</b>	
<b>Prescriber Name:</b>		
<b>Prescriber Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Prescriber Phone:</b>	<b>Prescriber Fax:</b>	
<b>Diagnosis:</b>	<b>ICD Code(s):</b>	

<b>Please circle the appropriate answer for each question.</b>			
1	Is the requested drug being prescribed to reduce the risk of overt hepatic encephalopathy (HE) recurrence? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed for the treatment of irritable bowel syndrome with diarrhea (IBS-D)? [If no, then skip to question 6.]	Yes	No
3	Has the patient previously received treatment with the requested drug? [If no, then no further questions.]	Yes	No
4	Is the patient experiencing a recurrence of symptoms? [If no, then no further questions.]	Yes	No
5	Has the patient already received an initial 14-day course of treatment AND two additional 14-day courses of treatment with the requested drug? [No further questions.]	Yes	No
6	Is the requested drug being prescribed for small intestinal bacterial overgrowth (SIBO) syndrome? [If no, then no further questions.]	Yes	No

7	Is the patient experiencing a recurrence after completing a successful course of treatment with the requested drug? [If yes, then no further questions.]	Yes	No
8	Has the diagnosis been confirmed by one of the following: A) quantitative culture of upper gut aspirate, B) breath testing (e.g., lactulose hydrogen or glucose hydrogen breath test)?	Yes	No

Comments:	
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By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

<b>Prescriber (or Authorized) Signature:</b> _____ <b>Date:</b> _____
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