US Family Health Plan
Prior Authorization Request Form for
rifaximin (**Xifaxan**) 550 mg

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1

Please complete patient and physician information (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2

Please complete the clinical assessment:

1. Is the patient greater than or equal to 18 years old?	☐ Yes proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Will this medication be used for treatment of hepatic encephalopathy?	☐ Yes **Sign and date below**	☐ No proceed to question **3**
3. Does the patient have a diagnosis of IBS-diarrhea type, without constipation, and have symptoms of moderate abdominal pain and bloating?	☐ Yes proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the prescription written by or in consultation with a gastroenterologist?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is there documentation that the patient has failure of dietary changes (including fiber), stress reduction, or cognitive behavioral therapy?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Has the patient had a failure, intolerance, or contraindication to at least one antispasmodic/antidiarrheal agent (for example, dicyclomine [Bentyl], Librax, hyoscyamine [Levsin], Donnatal, loperamide [Imodium])?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**

Prior Authorization Request Form for
rifaximin (**Xifaxan**) 550 mg

7. Has the patient had a failure, intolerance, or contraindication to at least one tricyclic antidepressant (that is, to relieve abdominal pain) (for example, amitriptyline, desipramine, doxepin, imipramine, nortriptyline, protriptyline)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

† Coverage is NOT provided for the treatment of other conditions not listed above, including: small intestinal bacterial overgrowth (SIBO), non-alcoholic steatohepatitis (NASH) or non-alcoholic fatty liver disease (NAFLD), spontaneous bacterial peritonitis (SBP), functional dyspepsia, diabetes, cirrhosis (ascites/alcohol-related), graft vs host disease, primary sclerosing cholangitis, Celiac disease, ulcerative colitis, Crohn's disease, diverticular disease, bowel preparation, constipation, colorectal cancer prevention, opioid-induced constipation, chronic abdominal pain, or other disease states.

- Prior authorization for rifaximin for IBS-D expires every 12 months **AND** only up to 3 courses will be authorized during a 12 month period.

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____

[15 May 2019]