Updated: 06/2020
DMMA Approved: 06/2020

Request for Prior Authorization for Xifaxan
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Xifaxan require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Xifaxan Prior Authorization Criteria:

For all requests for Xifaxan all of the following criteria must be met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Coverage may be provided with a diagnosis of Traveler's Diarrhea and the following criteria is met:

- Medication strength must be Xifaxan 200mg tablet
- Member is 12 years of age or older
- Member must have diagnosis of traveler's diarrhea caused by non-invasive strains of *Escherichia coli*
- Member must have a history of trial and failure, contraindication, or intolerance to a 3-day course of twice daily ciprofloxacin
- Member must not have diarrhea complicated by fever or bloody stools
- **Initial Duration of Approval:** 3-day course of therapy (9 tablets) of the 200 mg tablets in any 30-day period.
- **Reauthorization criteria**
    - Member must be reevaluated for preauthorization

Coverage may be provided with a diagnosis of Hepatic Encephalopathy and the following criteria is met:

- Medication strength must be Xifaxan 550mg tablet
- Member is 18 years of age or older
- Member must have a history of trial and failure, contraindication, or intolerance of at least 2 days of treatment with nonabsorbable disaccharides (i.e. lactulose, lactitol)
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Clinical documentation of improvement in member's mental status.
- **Reauthorization Duration of Approval:** 6 months

Coverage may be provided with a diagnosis of Irritable Bowel Syndrome (IBS) with diarrhea and the following criteria is met:

- Medication strength must be Xifaxan 550mg tablet
- Member is 18 years of age or older
- Member must have failed dietary modifications [e.g. lactose restricted diet, if lactose intolerant; exclusion of gas-producing foods; low carbohydrate diet, and elimination of fermentable oligo-, di-, and monosaccharides and polyols (FODMAPs)].
- Member must have a history of trial and failure, contraindication, or intolerance to ALL of the following:

  - Two-week trial of antispasmodic agents (e.g. dicyclomine, hyoscyamine)
  - Six-week trial of Tricyclic antidepressants (e.g. amitriptyline, imipramine)
- **Initial Duration of Approval:** 14 days
- **Reauthorization criteria**
  - There must be documented, significant improvement with prior courses of treatment.
  - Member will have a limit of three 14-day course treatments. Member must wait 1 full month before being reevaluated for preauthorization.

Reauthorization Duration of Approval: 14 days

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK. Delaware HEALTH OPTIONS

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XIFAXAN
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Which of the following diagnoses will the medication be used for:

a. Traveler's Diarrhea ☐ Yes ☐ No
   If yes, please answer questions below:
   i. Is the strength being prescribed Xifaxan 200mg? ☐ Yes ☐ No
   ii. Is member 12 years of age or older? ☐ Yes ☐ No
   iii. Does member have diagnosis of traveler's diarrhea caused by non-invasive strains of *Escherichia coli?* ☐ Yes ☐ No
   iv. Does member must have diarrhea complicated by fever or bloody stools? ☐ Yes ☐ No

b. Hepatic Encephalopathy ☐ Yes ☐ No
   If yes, please answer questions below:
   i. Is strength being prescribed Xifaxan 550mg tablet? ☐ Yes ☐ No
   ii. Is member 18 years of age or older? ☐ Yes ☐ No
   iii. Does member have a history of trial and failure, contraindication, or intolerance of at least 2 days of treatment with nonabsorbable disaccharides (i.e. lactulose, lactitol)? ☐ Yes ☐ No

c. Irritable Bowel Syndrome (IBS) with diarrhea ☐ Yes ☐ No
   If yes, please answer questions below:
   i. Is strength being prescribed Xifaxan 550mg tablet? ☐ Yes ☐ No

ii. Is member 18 years of age or older? ☐ Yes ☐ No

iii. Has member failed dietary modifications [e.g. lactose restricted diet, if lactose intolerant; exclusion of gas-producing foods; low carbohydrate diet, and elimination of fermentable oligo-, di-, and monosaccharides and polyols (FODMAPs)]? ☐ Yes ☐ No

iv. Does member have a history of trial and failure, contraindication, or intolerance to any of the following: (Please check all that apply):

1. Two-week trial of antispasmodic agents (e.g. dicyclomine, hyoscyamine) ☐ Yes ☐ No
2. Six-week trial of Tricyclic antidepressants (e.g. amitriptyline, imipramine) ☐ Yes ☐ No

d. Other Diagnosis: _____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

1. Which of the following diagnoses is the member using medication for?
   a. Hepatic Encephalopathy ☐ Yes ☐ No

   If yes, please answer questions below:

   i. Is there clinical documentation of improvement in member's mental status?
   ☐ Yes ☐ No

   b. Irritable Bowel Syndrome (IBS) with diarrhea ☐ Yes ☐ No

   i. Has the member experienced a significant improvement with treatment?
   ☐ Yes ☐ No

   ii. Please describe:

   c. Other diagnosis: _____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date