PA Request Criteria

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237239

CAREFIRST - ANNE ARUNDEL COUNTY PUBLIC SCHOOLS (AACPS)
Xifaxan 200mg Limit-Post Limit

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Xifaxan 200mg Limit-Post Limit.

Patient Name: _____ **Date:** 8/25/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (select from list of drugs shown)
Xifaxan 200mg (rifaximin)

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____

Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being prescribed for the treatment of moderate to severe travelers' diarrhea (TD) caused by noninvasive strains of Escherichia coli?	**Y** ☐	**N** ☐
2.	Is the patient 12 years of age or older?	**Y** ☐	**N** ☐
3.	Is the infection proven or strongly suspected to be caused by susceptible bacteria based on culture and susceptibility information OR local epidemiology and susceptibility patterns?	**Y** ☐	**N** ☐
4.	Does the patient require additional quantities due to multiple occurrences of travelers' diarrhea (TD) in a one-month period? [If diarrhea worsens or persists for more than 24-48 hours after initiating rifaximin, the drug should be discontinued and an alternative anti-infective considered.]	**Y** ☐	**N** ☐
5.	Does the patient require MORE than the plan allowance of 18 tablets (2 courses of treatment) in one month?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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