PA Request Criteria

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237240

CAREFIRST - ANNE ARUNDEL COUNTY PUBLIC SCHOOLS (AACPS)
Xifaxan 550mg

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 550mg.

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 550mg (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 to reduce the risk of overt hepatic encephalopathy (HE) recurrence?	**Y** ☐	**N** ☐
2.	Is the requested drug being used as add-on therapy to lactulose?	**Y** ☐	**N** ☐
3.	Is the requested drug being prescribed for the treatment of irritable bowel syndrome with diarrhea (IBS-D)?	**Y** ☐	**N** ☐
4.	Has the patient previously received treatment with the requested drug for irritable bowel syndrome with diarrhea (IBS-D)?	**Y** ☐	**N** ☐
5.	Is the patient experiencing a recurrence of symptoms?	**Y** ☐	**N** ☐
6.	Has the patient received fewer than three 14-day courses of treatment with the requested drug for the treatment of irritable bowel syndrome with diarrhea (IBS-D)?	**Y** ☐	**N** ☐
7.	Is the requested drug being prescribed for the treatment of small intestinal bacterial overgrowth (SIBO)?	**Y** ☐	**N** ☐
8.	Is the patient experiencing a recurrence of small intestinal bacterial overgrowth (SIBO) after completion of a successful course of the requested drug?	**Y** ☐	**N** ☐
9.	Has the patient's 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)?	**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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