BlueCross BlueShield Federal Employee Program

XIFAXAN
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Xifaxan (rifaximin)

NOTE: Form must be completed in its **entirety** for processing

Please select strength: ❑**200mg** ❑**550mg**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?

❑Hepatic encephalopathy

a. Will the patient need more than 180 tablets every 90 days? ❑Yes* ❑No

***If YES**, please specify the requested quantity: _____ tablets every 90 days

❑Irritable bowel syndrome with diarrhea (IBS-D)

a. Has the patient had an inadequate treatment response to dietary modification such as low carbohydrate diet, exclusion of gas producing foods, or lactose free diet if intolerant? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have an inadequate treatment response to **TWO** anti-diarrheal medications? ❑Yes ❑No

c. Will the patient need more than 126 tablets (3x14 day cycles) for 365 days? ❑Yes* ❑No

***If YES**, please specify the requested quantity: _____ tablets for 365 days

❑Small intestinal bacterial overgrowth (SIBO)

a. Has the patient had an inadequate treatment response to dietary modification such as low carbohydrate diet, exclusion of gas producing foods, or lactose free diet if intolerant? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to another antibiotic for SIBO (e.g., amoxicillin-clavulanic acid, ciprofloxacin, metronidazole, etc.)? ❑Yes ❑No

c. Will the patient need more than 126 tablets (3x14 day cycles) for 365 days? ❑Yes* ❑No

***If YES**, please specify the requested quantity: _____ tablets for 365 days

❑Prevention of traveler's diarrhea

a. Will the patient need more than 28 tablets for 90 days? ❑Yes* ❑No

***If YES**, please specify the requested quantity: _____ tablets for 90 days

❑Traveler's diarrhea

a. Is the patient experiencing traveler's diarrhea caused by noninvasive strains of *Escherichia coli* (E coli)? ❑Yes ❑No

b. Will this medication be used in combination with another Prior Authorization (PA) medication for Traveler's diarrhea, such as Aemcolo? ❑Yes* ❑No

***If YES**, please specify the medication: _____

c. Will the patient need more than 9 tablets for 90 days? ❑Yes* ❑No

***If YES**, please specify the requested quantity: _____ tablets for 90 days

❑Other diagnosis ***(please specify)***: _____***(please answer the following question)***

a. How many tablets will the patient need for a 90 day supply? _____ tablet(s) per 90 days

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Xifaxan – FEP MD Fax Form Revised 8/27/2024

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***