Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Xifaxan

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Xifaxan.
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Xifaxan (rifaximin)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Does the patient have diarrhea with a documented culture indicating that the causative microorganism is E. Coli? [If no, then skip to question 4.]	Y	N
2. Is the patient 12 years of age or older?	Y	N
3. Is the patient experiencing fevers and/or bloody stools? [No further questions.]	Y	N
4. Is the patient 18 years of age or older?	Y	N
	Y	N

5.	Does the patient have a confirmed (from medical records or diagnosis codes) diagnosis of hepatic encephalopathy? [If no, then skip to question 7.]	Y	N
6.	Is the patient currently on or has the patient had a documented trial with lactulose? [No further questions.]	Y	N
7.	Does the patient have a diagnosis of Irritable Bowel Syndrome (IBS) with diarrhea as the predominant symptom, confirmed with colonoscopic examination within the previous 2 years? [Note: A copy of colonoscopy results should be submitted or addressed in the MD progress notes.]	Y	N
8.	Has the patient had a documented trial of three of the following treatment options since the diagnosis of IBS: A) Lifestyle and dietary modifications (elimination of caffeine, lactose, or fructose from diet, addition of fiber to diet, use of probiotics), B) Antidiarrheals (i.e., loperamide, cholestyramine). C) Antispasmodics (i.e., dicyclomine, hyoscyamine), D) Tricyclic Antidepressants (i.e., desipramine, amitriptyline, doxepin)	Y	N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date