GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

XIFAXAN (rifaximin) PRIOR AUTHORIZATION FORM *(form effective 01/03/2022)*

Prior authorization guidelines for **Antibiotics, GI and Related Agents** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested: Xifaxan tablet	Strength: ☐200 mg ☐550 mg ☐ _____		
Dose/directions: ☐200 mg three times daily x 3 days ☐550 mg three times daily x 14 days ☐550 mg twice daily ☐other: _____		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

INITIAL requests - complete questions applicable to beneficiary's diagnosis		
***Hepatic encephalopathy*: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of **lactulose**?**	☐Yes ☐No	*Submit documentation.*
***Travelers' diarrhea*: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of azithromycin (Zithromax)?**	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
***Irritable bowel syndrome with diarrhea (IBS-D)*: Is Xifaxan being prescribed by or in consultation with a gastroenterologist?**	☐Yes ☐No	*Submit documentation of consultation, if applicable.*
***IBS-D*: Did the beneficiary try and fail a low FODMAP diet?**	☐Yes ☐No	*Submit documentation of dietary changes tried and outcomes.*
RENEWAL requests - complete questions applicable to beneficiary's diagnosis		
***Irritable bowel syndrome with diarrhea (IBS-D)*: Was the beneficiary's previous treatment course with Xifaxan successful?**	☐Yes ☐No	*Submit documentation of clinical response.*
***IBS-D*: Have the beneficiary's symptoms of IBS-D recurred since the previous treatment course?**	☐Yes ☐No	*Submit documentation.*
IBS-D*: How many treatment courses of Xifaxan has the beneficiary had? *Submit documentation.	☐one ☐two ☐other: _____	

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	**Date**:

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