Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Xifaxan 550 MG

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of hepatic encephalopathy (HE)? Please attach documentation to confirm diagnosis. If YES, go to 3. If NO, go to 5.

☐ Yes ☐ No

Q3. Has the patient had an inadequate response, intolerance, or contraindication to lactulose?

☐ Yes ☐ No

Q4. Will the dosing for HE be 550 mg twice a day?

☐ Yes ☐ No

Q5. Does the patient have a diagnosis of irritable bowel syndrome (IBS) with diarrhea? Please attach chart notes/medical records to confirm diagnosis.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Has the patient had inadequate response, intolerance, or contraindication to one antispasmodic agent (e.g., dicyclomine) or one anti-diarrheal agent (e.g., diphenoxylate/atropine, loperamide)?

☐ Yes ☐ No

Q7. Will the dosing for IBS with diarrhea be 550 mg three times a day?

☐ Yes ☐ No

Q8. Does the patient have a confirmed diagnosis of small intestinal bacterial overgrowth (SIBO) by 1) Glucose hydrogen or lactulose hydrogen breath tests or 2) Small bowel aspirate and culture.?

☐ Yes ☐ No

Q9. Will the dosing for SIBO be 550 mg three times a day?

☐ Yes ☐ No

Q10. Additional Information:

_____ _____

Prescriber Signature Date

v2025