Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Xifaxan 550 MG - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	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 applying the 72 hour 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 requested drug being prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist?

☐ Yes ☐ No

Q2. Does the patient have documentation of a diagnosis of Hepatic Encephalopathy (HE)? If YES, go to 3. If NO, go to 6.

☐ Yes ☐ No

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

☐ Yes ☐ No

Q4. Will the dosing for Hepatic Encephalopathy (HE) be 550 mg twice a day?

☐ Yes ☐ No

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q6. Does the patient have documentation of a diagnosis of irritable bowel syndrome (IBS) with diarrhea? If YES, go to 7. If NO, go to 10.

☐ Yes ☐ No

Q7. Has the patient had inadequate response, intolerance, or contraindication to one anti-diarrheal agent (loperamide)?

☐ Yes ☐ No

Q8. Will the dosing for irritable bowel syndrome (IBS) with diarrhea be 550 mg three times a day?

☐ Yes ☐ No

Q9. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q10. Does the patient have a confirmed diagnosis of small intestinal bacterial overgrowth (SIBO) by results of glucose hydrogen or lactulose hydrogen breath tests OR small bowel aspirate and culture?

☐ Yes ☐ No

Q11. Will the dosing for small intestinal bacterial overgrowth (SIBO) be 550 mg three times a day for 14 days?

☐ Yes ☐ No

Q12. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q13. Requested Duration:

☐ 14 Days ☐ Other:

Q14. Additional Information:

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Member Name:	**Prescriber Name:**

Prescriber Signature

Date

v2026