Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Xifaxan Renewal

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	Prescriber PA PROMISe ID:	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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. Has the patient previously been treated with Xifaxan for hepatic encephalopathy (HE)?

☐ Yes ☐ No

Q2. Has the patient been compliant and tolerated to treatment? (Please attach documentation).

☐ Yes ☐ No

Q3. Has the patient previously been treated with Xifaxan for moderate to severe IBS with diarrhea?

☐ Yes ☐ No

Q4. Does the patient have residual symptoms such as abdominal pain, bloating, and diarrhea that would require retreatment and it is at least 10 weeks after the last dose of the previous treatment. (Please attach documentation)?

☐ Yes ☐ No

Q5. Requested duration:

☐ 12 months ☐ 14 days

Q6. Additional Information:

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Patient Name:	**Prescriber Name:**
Prescriber Signature	Date

Updated 2018