Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Rifaximin (Xifaxan) – Medical Necessity Request

****Please complete page 1 and 2 for New/Initial Requests****

Diagnosis Information (please indicate diagnosis and answer related questions):

□ **Traveler's Diarrhea**

a. What is the severity of the member's Traveler's Diarrhea? _____

b. What organism(s) is/are causing the diarrhea? _____

c. Is the member 12 years of age or older? **Yes** or **No**

d. Does the member have a fever? **Yes** or **No**

e. Does the member have blood in the stool? **Yes** or **No**

f. Has the member tried azithromycin?

□ **Yes:** Why was it discontinued? _____

□ **No:** Can the member try azithromycin?

□ **Yes:** Please notify the pharmacy of the change.

□ **No**: Why can't azithromycin be tried? _____

□ **Overt Hepatic Encephalopathy**

a. Is the member 18 years of age or older? **Yes** or **No**

b. Has the member tried lactulose alone?

□ **Yes**: Has it been discontinued?

□ **Yes:** Why was it discontinued? _____

□ **No**: Why can the member not use lactulose alone? _____

□ **No**: Can the member try lactulose alone?

□ **Yes:** Please notify the pharmacy of the change.

□ **No**: Why can't lactulose be tried alone? _____

□ **Liver Cirrhosis**

a. Is the member 18 years of age or older? **Yes** or **No**

b. Is Xifaxan being used for overt hepatic encephalopathy? **Yes or No**

c. Has the member tried lactulose alone?

□ **Yes**: Has it been discontinued? **Yes or No**

□ **Yes:** Why was it discontinued? _____

□ **No**: Why can the member not use lactulose alone? _____

□ **No**: Can the member try lactulose alone?

□ **Yes:** Please notify the pharmacy of the change.

□ **No**: Why can't lactulose be tried alone? _____

□ **Irritable Bowel Syndrome with Diarrhea**

a. Is the member 18 years of age or older? **Yes** or **No**

b. How many days of Xifaxan therapy has the member already received? _____

c. Is the request for more than 14 days of therapy? **Yes** or **No**

i. If Yes, what is the clinical reason for requesting more than 14 days of therapy?

_____

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ **Recurrent Clostridium difficile (C. diff) infection**

a. Is the member 18 years of age or older? **Yes** or **No**

b. Will Xifaxan be used after a course of vancomycin? **Yes** or **No**

c. Is the request for more than 20 days of therapy? **Yes** or **No**

i. If Yes, what is the clinical reason for requesting more than 20 days of therapy?

_____

□ **Other**: _____

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Complete this page for Subsequent Requests

Diagnosis Information (please indicate diagnosis and answer related questions):

□ **Hepatic Encephalopathy**

□ **Liver Cirrhosis**

a. Is Xifaxan being used for overt hepatic encephalopathy?

□ **Yes**

□ **No**

□ **Irritable Bowel Syndrome with Diarrhea**

a. Is the member experiencing recurrence symptoms (i.e. abdominal pain or loose or watery stool consistency)? **Yes** or **No**

b. How many weeks have passed since the previous Xifaxan treatment ended? _____

c. How many days of therapy has the member already received? _____

d. Is the request for more than 14 days of therapy? **Yes** or **No**

i. If Yes, what is the clinical reason for requesting more than 14 days of therapy?

_____

□ **Other**: _____

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**