Horizon NJ Health
Rifaximin (Xifaxan) – Medical Necessity Request

*Please complete page 1 for New/Initial Requests*

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

☐ Traveler’s Diarrhea
  a. Is the medication being prescribed for the treatment or prophylaxis (prevention) of Traveler’s Diarrhea?
     □ Treatment
     □ Prophylaxis (prevention)
  b. What is the severity of the member’s Traveler’s Diarrhea? ___________________________________________
  c. What organism(s) is/are causing the diarrhea? ______________________________________________________
  d. Is the member 12 years of age or older? Yes or No
  e. Does the member have a fever? Yes or No
  f. Does the member have blood in the stool? Yes or No
  g. Has the member tried azithromycin?
     □ Yes: Why was it discontinued? ____________________________________________________________
     □ No: Can the member try azithromycin?
        □ Yes
        □ No: Why can’t azithromycin be tried?

☐ Hepatic Encephalopathy
  a. Is the member 18 years of age or older? Yes or No
  b. Is Xifaxan being used for the prevention (prophylaxis) or treatment of hepatic encephalopathy?
     □ Prevention □ Treatment
  c. Has the member tried lactulose?
     □ Yes: Why was it discontinued? __________________________________________________________
     □ No: Can the member try lactulose?
        □ Yes
        □ No: Why can’t lactulose be tried?

☐ 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?
        ______________________________________________________________________________________

☐ Other: ____________________________________________________________________________________________

*Form must be completed and signed by physician or licensed representative from the physician’s office
Complete this page for Subsequent Request

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

□ Hepatic Encephalopathy  
  a. Is Xifaxan being used for the prevention (prophylaxis) or treatment of hepatic encephalopathy?  
     □ Prevention  
     □ Treatment

□ 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 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  
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

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