

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 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:** \_\_\_\_\_

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 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**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician office's signature\* \_\_\_\_\_ Print Name \_\_\_\_\_

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