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 alone?
- □ Yes:
  - Has it been discontinued? **Yes or No**
    - If no, why can the member not use lactulose alone? _____
- □ No: Can the member try lactulose alone?
  - □ **Yes**
  - □ **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 the prevention (prophylaxis) or treatment of hepatic encephalopathy? **Yes or No**

c. Has the member tried lactulose alone?
- □ Yes:
  - Has it been discontinued? **Yes or No**
    - If no, why can the member not use lactulose alone? _____

**Continued to page 2**

**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: _____

□ No: Can the member try lactulose alone?

□ **Yes**

□ **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?

_____

□ **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

□ **Liver Cirrhosis**

a. Is Xifaxan being used for the prevention (prophylaxis) or treatment of 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**