Prescriber Criteria Form

Xifaxan 550mg 2026 PA Fax 1480-A v1 010126.docx
Xifaxan 550mg Only (rifaximin)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Xifaxan 550mg Only (rifaximin).

Drug Name:
Xifaxan 550mg Only (rifaximin)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed to reduce the risk of overt hepatic encephalopathy (HE) recurrence? [If yes, then no further questions.]	Yes	No
2	Is the requested drug being prescribed for the treatment of irritable bowel syndrome with diarrhea (IBS-D)? [If no, then skip to question 6.]	Yes	No
3	Has the patient previously received treatment with the requested drug? [If no, then no further questions.]	Yes	No
4	Is the patient experiencing a recurrence of symptoms? [If no, then no further questions.]	Yes	No
5	Has the patient already received an initial 14-day course of treatment AND two additional 14-day courses of treatment with the requested drug? [No further questions.]	Yes	No
6	Is the requested drug being prescribed for small intestinal bacterial overgrowth (SIBO) syndrome? [If no, then no further questions.]	Yes	No

7	Is the patient experiencing a recurrence after completing a successful course of treatment with the requested drug? [If yes, then no further questions.]	Yes	No
8	Has the diagnosis been confirmed by one of the following: A) quantitative culture of upper gut aspirate, B) breath testing (e.g., lactulose hydrogen or glucose hydrogen breath test)?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____