

Please note: All information below is required to process this request.

Fax to 1-844-403-1029 Mon-Sat: 7am to 7pm Central

## Xifaxan® Prior Authorization Request Form

	DO NOT COPY F	OR FUTURE USE. FORMS	ARE UPDATED FREQ	UENTLY AND MAY BE	BARCODED	
Member Information (required)				Provider Information (required)		
Member Name:			Provider Nar	Provider Name:		
Insurance ID#:			NPI#:		Specialty:	
Date of Birth:			Office Phone	Office Phone:		
Street Address:			Office Fax:	Office Fax:		
City:	State:	Zip:	Office Street	Office Street Address:		
Phone:		<b>'</b>	City:	State:	Zip:	
Medication Information (required)						
Medication Name:			Strength:		Dosage Form:	
☐ Check if requesting <b>brand</b>			Directions fo	r Use:		
☐ Check if re	quest is for <b>continuation</b>	of therapy				
		Clinical I	nformation (re	equired)		
Select the diagnosis below:						
☐ Hepatic encephalopathy (HE)						
☐ Irritable bowel syndrome with diarrhea (IBS-D)						
☐ Travelers' diarrhea						
☐ Other diagnosis:			ICD-10 C	ICD-10 Code(s):		
Are there any this review?	other comments, diagnose	es, symptoms, medication	s tried or failed, and/o	r any other information	n the physician feels is important to	
Please note:	For urgent or expedited	enied unless all required info d requests please call 1-855 for non-urgent requests and	-401-4262.	)29.		

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