CareFirst
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

Prior Authorization Form

CAREFIRST

Xifaxan 550mg

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 **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Xifaxan 550mg.

Drug Name (select from list of drugs shown)
Xifaxan 550mg (rifaximin)

Quantity | Frequency | Strength

Route of Administration | Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is Xifaxan being prescribed to reduce the risk of overt hepatic encephalopathy recurrence?	Y N
	[If yes, then no further questions.]	
2.	Does the patient have the diagnosis of irritable bowel syndrome with diarrhea?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date