



The CareFirst BlueCross BlueShield family of health care plans



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

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