



Date of Request: \_\_\_\_\_

**Sterling Retiree Rx Prior Authorization Form**

**XIFAXAN**

**Coverage Criteria / Required Medical Information:**

All FDA approved indications not otherwise excluded from Part D; 18 years of age or older

**Coverage Duration:** Hepatic encephalopathy-6 months

**Exclusion Criteria:**

Hypersensitivity reaction to rifamycin antimicrobial agents. For hepatic encephalopathy, Xifaxan exceeding the recommended dose of two 550mg tablets daily.

**Member Information**

<b>Name</b>					
<b>Enrollment/Card-holder ID Number</b>					
<b>Group/Plan</b>		<b>Male</b>		<b>Female</b>	
<b>Date of Birth</b>		<b>Age</b>		<b>Weight in Kg</b>	
<b>Street Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	

**Physician Information**

<b>Name</b>					
<b>Agent</b>		<b>Contact Name</b>			
<b>Specialty/Office</b>					
<b>Clinic Name</b>					
<b>Street Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	
<b>Phone</b>		<b>Fax</b>			

**Requested Drug**

<b>XIFAXAN</b>	<b>Reason for Request</b>	
<b>Condition/Diagnosis Related</b>		

**Clinical Drug/Lab History Pertinent to Request**

<b>Labs: Baseline/Ongoing</b>	<b>Strength/Dosage</b>			
<b>Formulary Alternative(s) Attempted?</b>	<b>Yes:</b>		<b>No:</b>	
<b>Please List Alternative Formulary Drugs</b>				

<b>Comments</b>	
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Physician Signature: \_\_\_\_\_

**Fax Form to 1-866-481-3704**