XIFAXAN
PRIOR AUTHORIZATION

SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for Xifaxan must meet the following criteria:

- Patient must have a diagnosis of travelers' diarrhea (TD) caused by noninvasive strains of E.coli and be 12 years of age or older.
- Patient must have a diagnosis of hepatic encephalopathy (HE) and be ≥ 18 years of age and failed a trial of lactulose.
- TD usual dose – 200mg three times a day for 3 days
- HE usual dose – 550mg twice a day (1100mg/day)

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	MEDICAID ID NUMBER:	RECIPIENT DATE OF BIRTH

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:	
CITY:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: □ **Xifaxan 200mg** □ **Xifaxan 550mg**	Diagnosis for this request: Date of lactulose trial for Xifaxan 550mg:
PHYSICIAN SIGNATURE: DATE:	

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
PHONE: ( ):	FAX:: ( )
DRUG:	NDC#:

Part V: FOR OFFICIAL USE ONLY

Date: / / Initials: _____
Approved - Effective dates of PA: From: / / To: / /
Denied: (Reasons)