CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: **Xifaxan 550mg**

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Incomplete responses may delay this request.			
Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone #:		Provider Fax #:	Provider NPI #:
Patient Name:	CCHP Member ID #:	Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Quantity Dispensed (including units):

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

New medication **Ongoing medication**	If ongoing, please provide start date:	If ongoing, did the member show improvement while on therapy?	☐ **Yes** ☐ **No**

Diagnosis:

Please indicate place of administration:

Physician's Office ☐ **Hospital/Facility** ☐ **Patient Home** ☐ **Other** ☐

Please provide hospital/facility information:
Name: _____
Phone #: _____
Address: _____
_____

Will the drug be: (select one)
☐ **Billed medically using a JCODE**
JCODE:
☐ **Billed by a pharmacy and delivered to the provider**
☐ **Billed by a pharmacy and delivered to the patient**

Medical History

☐ Hepatic Encephalopathy

Has the member previously tried lactulose? ☐ **Yes** ☐ **No**
If yes, please provide dates of trial and reason for discontinuation:

If no, please provide reason for not using lactulose:

☐ Diarrhea-predominant Irritable Bowel Syndrome (IBS-D)

Please provide chart documentation describing how the diagnosis was confirmed and showing chronic IBS symptoms.
☐ Enclosed ☐ Not available

Please indicate below any other medications previously used to treat the member's condition:

Medication name	Start date	End date	Strength	Frequency	Reason for failure, discontinuation

Please provide any additional clinical information which should be considered in the space below:					