

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	<b>Specialty/facility name (if applicable):</b>	

**REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.  
Please answer the following questions and sign.**

Q1. Does the patient have hypersensitivity to rifaximin, any of the rifamycin antimicrobial agents, or any component of the formulation?

Yes  No

Q2. Is the requested drug being prescribed by or in consultation with a Gastroenterologist, Hepatologist, or Infectious Disease specialist?

Yes  No

Q3. Does the patient have a confirmed diagnosis of Travelers' Diarrhea (TD) caused by noninvasive strains of Escherichia coli (E. coli) with treatment failure or inadequate response to a fluoroquinolone (e.g., ciprofloxacin, levofloxacin) or azithromycin? If No, go to 6.

Yes  No

Q4. Will the dosing for Travelers' Diarrhea (TD) be 200 mg three times a day?

Yes  No

Q5. Is the patient 12 years of age or older?

Yes  No

Q6. Does the patient have a diagnosis of Hepatic Encephalopathy (HE)? Please attach documentation to confirm diagnosis. If No, go to 10.

Yes  No

Q7. Has the patient had a trial of or inadequate response to lactulose?

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<b>Patient Name:</b>	<b>Prescriber Name:</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Will the dosing for Hepatic Encephalopathy (HE) be 550 mg twice a day?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Does the patient have a diagnosis of Irritable Bowel Syndrome (IBS) with diarrhea? Attach chart note/medical records to confirm diagnosis.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. Has the patient had inadequate response, intolerance or contraindication to one antispasmodic agent (e.g., dicyclomine) or one anti-diarrheal agent (e.g., diphenoxylate/atropine, loperamide)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. Will the dosing for Irritable Bowel Syndrome (IBS) with diarrhea be 550 mg three times a day?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. Is the patient 18 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Additional Information:	
Q15. Duration:	
<input type="checkbox"/> 3 days for Traveler's diarrhea	
<input type="checkbox"/> 14 days for IBS w/diarrhea	
<input type="checkbox"/> 12 months for Hepatic Encephalopathy	
<input type="checkbox"/> Other	

\_\_\_\_\_  
 Prescriber Signature

\_\_\_\_\_  
 Date

2023 Medicare Prior Authorization Request