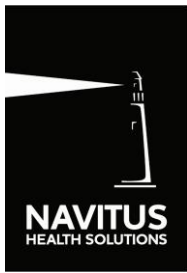




TEXAS MEDICAID
Clinical Edit Prior Authorization
rifaximin 550mg (XIFAXAN 550mg)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:
Patient's Primary Diagnosis: _____ ICD 10 Code: _____	
Please indicate ONE (1) of the following: <input type="checkbox"/> STAR / STAR KIDS client (Go to Step 3 - PDL PA Criteria Applies) OR <input type="checkbox"/> CHIP / PERINATE client (Go to Step 4)	
STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT	
1. Does the client have a diagnosis of hepatic encephalopathy in the last 730 days? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #2)	
2. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the last 180 days? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #3)	
3. Is there a documented allergy or contraindication to preferred agents in this class? <input type="checkbox"/> Yes (Go to Step 4 Question 1) <input type="checkbox"/> No (Go to #4)	



4. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

Yes (Go to Step 4 Question 1) No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client greater than or equal to (\geq) 18 years of age?

Yes (Go to #2) No (Deny)

2. Does the client have a diagnosis of hepatic encephalopathy in the last 730 days?

Yes (Go to #4) No (Go to #3)

3. Does the client have a diagnosis of irritable bowel syndrome with diarrhea (IBS-D) in the last 730 days?

Yes (Go to #6) No (Deny)

4. Does the client have a 15-day history of lactulose in the last 90 days?

Yes (Go to #5) No (Deny)

5. Is the dose less than or equal to (\leq) 1,100mg per day?

Yes (Approve - 365 days) No (Deny)

6. Is the dose less than or equal to (\leq) 1,650mg per day?

Yes (Approve - 365 days) No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances. For questions, please call Navitus Customer Care at 1-877-908-6023.