

**Physician's Prior Authorization Questionnaire
Xifaxan® 550 mg Tablet**

Patient:

ID#:

DOB:

Patient Address:

Xifaxan ® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* _____
2. Does the patient have chronic liver disease? Yes No
3. Does the patient have a history of hepatic encephalopathy? Yes No

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx