



PA21 XIFAXAN (550MG) REQUEST
NOT required for recipients less than 21 years of age.

Executive Office of Health & Human Services
PRIOR AUTHORIZATION REQUEST FORM for RI MEDICAID FEE FOR SERVICE (FFS)
DXC Technology ATTN: PHARMACIST
301 Metro Center Blvd., 3rd Floor • Warwick, RI 02886 • FAX (401) 784-3889

CLIENT NAME _____ DOB: _____ MEDICAID ID NUMBER _____

PRESCRIBER NAME: _____ PRESCRIBER NPI #: _____

PRESCRIBER OFFICE ADDRESS: _____

OFFICE PHONE NUMBER: () _____

REQUESTER NAME: _____ RN /MD /R.PH: _____

PHONE NUMBER: () _____ FAX NUMBER: () _____

DRUG REQUESTED: _____ QTY / FILL _____

INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD 10 CODE.

___ IS THERE A DIAGNOSIS OF HEPATIC ENCEPHALOPATHY? (Y/N) ICD10 CODE _____

___ IS THE PATIENT 18 YEARS OF AGE OR OLDER? (Y/N)

___ IS THERE A HISTORY OF TREATMENT WITH LACTULOSE? (Y/N) DATE OF TREATMENT W/LACTULOSE: ___/___/___

___ IS THERE INADEQUATE RESPONSE OR CONTRAINDICATION TO LACTULOSE? (Y/N)

COMMENTS: _____

PRESCRIBER SIGNATURE _____ **DATE** _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

**RI Medicaid FFS PRIOR AUTHORIZATION FAX NUMBER 1-401-784-3889
CONTACT DXC TECHNOLOGY CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100**

FOR STATE USE ONLY:

APPROVAL: ___ YES ___ NO PRIOR AUTHORIZATION #: _____

EFFECTIVE DATES: FROM: _____ TO _____