**Criteria for Approval (all of the following must be met for each indication):**

1. Diagnosis of Traveler’s Diarrhea (Maximum 200mg three times daily for 3 days; Excludes prophylactic use) Age ≥ 12 years
   - Trial and failure of, or contraindication to, fluoroquinolone or azithromycin:
     - Medication used: __________________________
     - Details of failure: __________________________
     - Chart Note Page #: __________________________
   - Must reasonably be believed to be caused by Escherichia coli – please describe

2. Diagnosis of Hepatic Encephalopathy (Maximum 550mg twice daily)
   - Age ≥ 18 years
   - For prophylaxis of recurrence – please describe previous occurrences and therapies
     - Medication used: __________________________
     - Details of failure: __________________________
     - Chart Note Page #: __________________________
   - Trial and failure of, or contraindication to, properly titrated doses of lactulose – please describe.

**Re-authorization Criteria:**
Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.

**Initial Authorization:** Traveler’s Diarrhea: Three days
Hepatic Encephalopathy: One year

**Re-authorization:** Up to 1 year

**PROVIDER CERTIFICATION**
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Prescriber’s Signature __________________________ Date ____________