# Prior Authorization Request Form for Antibiotics, GI and Related Agents

**FAX this completed form to (877) 386-4695**

**OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720**

| I. PROVIDER INFORMATION | II. MEMBER INFORMATION |
|---|---|
| Prescriber Name: | Member Name: |
| Prescriber Specialty: | Identification #: |
| Office Contact Name: | Group #: |
| Group Name: | Date of Birth: |
| Fax #: | Medication Allergies: |
| Phone #: | |

| III. DRUG INFORMATION (One drug request per form) | | |
|---|---|---|
| Drug name and strength: | Dosage Interval (sig): | Qty. per Day & Duration: |

**IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)***

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

| | | |
|---|---|---|
| **Requests for all non-preferred medications**: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Antibiotics, GI and Related Agents? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.* | ☐ Yes<br>☐ No | *Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.* |

☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

***SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.***

**DIFICID (FIDAXOMICIN):**

- ☐ For the treatment of *Clostridioides difficile* infection (CDI), one of the following:
  - ☐ Has at least one of the following factors associated with a high risk of recurrence of CDI:
    - ☐ Age ≥65 years
    - ☐ Clinically severe CDI (Zar score ≥ 2):_____
    - ☐ Is immunocompromised
  - ☐ Has a recurrent episode of CDI
  - ☐ Is prescribed Dificid (fidaxomicin) as a continuation of therapy upon inpatient discharge

**TRAVELERS' DIARRHEA:**

- ☐ History of therapeutic failure, contraindication or intolerance to Azithromycin (start date and end date):_____

**HEPATIC ENCEPHALOPATHY:**

- ☐ History of therapeutic failure, contraindication or intolerance to Lactulose: _____

**IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D):**

- ☐ Prescribed by or in consultation with a gastroenterologist
  - History of therapeutic failure to a low fermentable olgio-, di-, and monosaccharides and polyols (FODMAP) diet:_____

**ZINPLAVA (BEZLOTOXUMAB):**

- ☐ Prescribed by or in consultation with a gastroenterologist or infectious disease specialist
- ☐ Has a recent stool test positive for toxigenic *Clostridioides difficile*
- ☐ Has at least one of the following factors associated with a high risk for recurrence of *Clostridioides difficile* infection (CDI):
    - ☐ Age ≥65 years
    - ☐ Extended use of one or more systemic antibacterial drugs
    - ☐ Clinically severe CDI (Zar score ≥ 2):_____
    - ☐ At least one previous episode of CDI within the past 6 months or a documented history of at least 2 previous episodes of CDI
    - ☐ Is immunocompromised
    - ☐ The presence of a hypervirulent strain of CDI bacteria (ribotypes 027, 078, or 244)
- ☐ Is prescribed Zinplava (bezlotoxumab) in conjunction with an antibiotic regimen that is consistent with the standard of care
- ☐ Has not received a prior course of treatment with Zinplava (bezlotoxumab)

**IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D) RENEWAL REQUESTS:**

- ☐ Member has experienced a successful initial treatment course
- ☐ Member has documented recurrence of IBS-D symptoms
- ☐ Member has not received 3 treatment courses with Xifaxan in lifetime

## IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

| | | |
|---|---|---|
| Appropriate clinical information to support the request on the basis of medical necessity must be submitted. | Provider Signature: | Date: |

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)