Prior Authorization Request Form for Antibiotics, GI and Related Agents

FAX this completed form to (844) 386-4695
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact 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 Medications Taken Previously (start and end date and dose):
☐ No [redacted]

☐ 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

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:[redacted]
  - ☐ 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:[redacted]
  - ☐ 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:

Pharmacy Department 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.)