ANTIBIOTICS, GI and RELATED AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

FAX this completed form to (844) 205-3386
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/

Prior authorization guidelines for **Antibiotics, GI and Related Agents** and **Quantity Limits/Daily Dose Limits** are available on on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/State/Zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Complete the section(s) below that apply to the member and this request.

Check all that apply and submit documentation for each item.

NOTE: XIFAXAN (rifaximin) TABLET is no longer a Medicaid-covered drug.

Bausch Health US, LLC ("BHC"), the manufacturer of Xifaxan, ceased participation the Medicaid Drug Rebate Program ("MDRP") effective October 1, 2025.

- Medicaid patients whose plans no longer provide coverage for our products may be eligible for single-source BHC pharmaceuticals through our Patient Assistance Program (PAP).
- To enroll, click on the "Application for Medicaid-Only Patients" link at https://www.bauschhealthpap.com/ or by calling 1-833-862-8727.

1. For treatment of TRAVELERS' DIARRHEA:

☐Has a history of trial and failure of or a contraindication or an intolerance to azithromycin

2. For DIFICID / FIDAXOMICIN for treatment of *CLOSTRIDIOIDES DIFFICILE* INFECTION:

☐Has at least one of the following risk factors associated with a high risk of recurrence of *Clostridioides difficile* infection:
- ☐65 years of age or older
- ☐Clinically severe *Clostridioides difficile* infection (Zar score ≥2)

☐ Immunocompromised status

☐ Has a recurrent episode of *Clostridioides difficile* infection

☐ Is prescribed Dificid (fidaxomicin) as a continuation of therapy upon inpatient discharge

3. For ALL OTHER NON-PREFERRED Antibiotics, GI and Related Agents and for ALL OTHER indications:

☐ Has a history of trial and failure of or a contraindication or an 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 drugs in this class.

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber 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.)