UnitedHealthcare Community Plan

Antibiotics, GI and Related Agents - Pennsylvania
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure, contraindication, or intolerance of the preferred agents (*see Preferred Drug List, "Antibiotics, GI and Related Agents" section)?** *(If yes, complete Section D above)*
CLOSTRIDIOIDES (FORMERLY CLOSTRIDIUM) DIFFICILE INFECTION, ADJUNCTIVE THERAPY - ZINPLAVA	
□ **Yes** □ **No**	**Is Zinplava prescribed by or in consultation with a gastroenterologist or an infectious disease specialist?**
□ **Yes** □ **No**	**Does the patient have a recent stool test positive for toxigenic Clostridium difficile?**
□ **Yes** □ **No**	**Does the patient have any of the following factors associated with a high risk for recurrence of Clostridium difficile infection (CDI)?** *(If yes, check which applies)* □ Age greater than or equal to 65 years □ Extended use of one or more systemic antibacterial drugs □ Clinically severe CDI (as defined by a Zar score greater than or equal to 2) □ At least one previous episode of CDI within the past 6 months or a documented history of at least two previous episodes of CDI □ Is immunocompromised □ The presence of a hypervirulent strain of CDI bacteria (ribotypes 027, 078, or 244)
□ **Yes** □ **No**	**Is the patient receiving Zinplava (bezlotoxumab) in conjunction with an antibiotic regimen that is consistent with the standard of care for the treatment of CDI?**
□ **Yes** □ **No**	**Has the patient received a prior course of treatment with Zinplava (bezlotoxumab)?**
□ **Yes** □ **No**	**Is there documentation from the prescriber attesting that the benefit of therapy is expected to outweigh the risks if the patient has a history of congestive heart failure?**
HEPATIC ENCEPHALOPATHY - XIFAXAN	
□ **Yes** □ **No**	**Does the patient have a diagnosis of hepatic encephalopathy?**
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure, contraindication, or intolerance to lactulose?** *(If yes, complete Section D above)*
IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D) - XIFAXAN	
□ **Yes** □ **No**	**Does the patient have a diagnosis of irritable bowel syndrome with diarrhea (IBS-D)?**
□ **Yes** □ **No**	**Is Xifaxan prescribed by or in consultation with a gastroenterologist?**
□ **Yes** □ **No**	**Has the patient had other etiologies for chronic diarrhea ruled out?**
□ **Yes** □ **No**	**Does the patient have a documented history of therapeutic failure of any of the following?** *(If yes, check which applies and complete Section D above)* □ Lactose, gluten, and artificial sweetener avoidance □ A low fermentable oligo-, di-, and monosaccharides and polyols (FODMAP) diet
□ **Yes** □ **No**	**Does the patient have a documented history of therapeutic failure, contraindication, or intolerance of any of the following?** *(If yes, check which applies and complete Section D above)* □ Loperamide □ A bile acid sequestrant
TRAVELER'S DIARRHEA - XIFAXAN	
□ **Yes** □ **No**	**Does the patient have a diagnosis of traveler's diarrhea?**
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure, contraindication, or intolerance to azithromycin or at least one fluoroquinolone?** *(If yes, complete Section D above)*
CONTINUATION OF THERAPY – IRRITABLE BOWEL SYNDROME – XIFAXAN (cont'd on the next page)	
□ **Yes** □ **No**	**Is there documentation of a successful initial treatment course?**
□ **Yes** □ **No**	**Is there documented recurrence of irritable bowel syndrome with diarrhea (IBS-D) symptoms?**

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Member First name:	Member Last name:	Member DOB:
□ Yes □ No	Has the patient received 3 treatment courses with Xifaxan (rifaximin) in their lifetime?	

Provider Signature: _____ Date: _____