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.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

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

Medication Information

Medication:	**Strength:**
Directions for use:	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____

ICD-10 Code(s): _____

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Previous Medication Trials / Contraindications

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Additional information that may be important for this review

UnitedHealthcare Community Plan

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

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ **Yes** □ **No**	**Does the patient have any of the following diagnoses?** *(If yes, check which applies)* □ Clostridioides difficile infection (CDI) □ Irritable bowel syndrome with diarrhea (IBS-D) □ Hepatic encephalopathy □ Travelers' diarrhea
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure, contraindication, or intolerance of the preferred* agents approved or medically accepted for the patient's diagnosis (*see Preferred Drug List, "Antibiotics, GI and Related Agents" section)?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
CLOSTRIDIOIDES DIFFICILE INFECTION (CDI) - DIFICID	
□ **Yes** □ **No**	**Does the patient have any of the following factors associated with a high risk for recurrence of CDI?** *(If yes, check which applies)* □ Age greater than or equal to 65 years □ Is immunocompromised □ Clinically severe CDI (as defined by a Zar score greater than or equal to 2)
□ **Yes** □ **No**	**Does the patient have a recurrent episode of CDI?**
□ **Yes** □ **No**	**Was the patient prescribed Dificid as a continuation of therapy upon inpatient discharge?**
CLOSTRIDIOIDES DIFFICILE INFECTION (CDI) - 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 Clostridioides difficile?**
□ **Yes** □ **No**	**Does the patient have any of the following factors associated with a high risk for recurrence of 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)?**
HEPATIC ENCEPHALOPATHY	
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure, contraindication, or intolerance to lactulose?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D) - XIFAXAN	
□ **Yes** □ **No**	**Is Xifaxan prescribed by or in consultation with a gastroenterologist?**
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure of a low fermentable oligo-, di-, and monosaccharides and polyols (FODMAP) diet?**
CONTINUATION OF THERAPY – IRRITABLE BOWEL SYNDROME – XIFAXAN	
□ **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?**
□ **Yes** □ **No**	**Has the patient received 3 treatment courses with Xifaxan (rifaximin) in their lifetime?**
TRAVELERS' DIARRHEA	
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure, contraindication, or intolerance to azithromycin?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*

Provider Signature: _____ **Date:** _____

UnitedHealthcare Community Plan

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