

SENTARA COMMUNITY PLAN (MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Gastrointestinal (GI) Antibiotics

DRUG REQUESTED: (Check box below that applies)

PREFERRED Drugs		
<input type="checkbox"/> metronidazole tab (250mg/500mg)	<input type="checkbox"/> vancomycin cap	<input type="checkbox"/> vancomycin for reconstitution oral soln kit (generic Firvanq™ soln)
Non-Preferred Drugs (Require a Prior Authorization)		
<input type="checkbox"/> Aemcolo™	<input type="checkbox"/> Alinia® <input type="checkbox"/> nitazoxanide (generic Alinia®)	<input type="checkbox"/> Difcid®
<input type="checkbox"/> Firvanq™ soln	<input type="checkbox"/> Flagyl® cap/tab/ER	<input type="checkbox"/> Likmez™
<input type="checkbox"/> metronidazole 125mg	<input type="checkbox"/> metronidazole cap	<input type="checkbox"/> neomycin
<input type="checkbox"/> paromomycin	<input type="checkbox"/> Solosec®	<input type="checkbox"/> Tindamax®
<input type="checkbox"/> tinidazole	<input type="checkbox"/> Vancocin®	<input type="checkbox"/> Vowst™ (refer to Vowst PA form)
<input type="checkbox"/> Xifaxan®		

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

1. **Aemcolo™** - (Length of Authorization: date of service)
 - ❖ Diagnosis of travelers' diarrhea with moderate diarrhea that is distressing or interferes with planned activities. ☐ Yes ☐ No
 - ❖ Documentation of a history of failure, contraindication, or intolerance to one or more of the following: Azithromycin (generic Zithromax), Ciprofloxacin (generic Cipro), Levofloxacin (generic Levaquin), Ofloxacin (generic Floxin). ☐ Yes ☐ No
2. **Alinia® tablets – Quantity Limit: 6 tabs per rolling 30 days** (Length of Authorization: date of service)
 - ❖ Member is ≥ 12 years old? ☐ Yes ☐ No
 - ❖ Diagnosis of diarrhea caused by *Cryptosporidium parvum* or *Giardia lamblia*, ☐ Yes ☐ No
 - ❖ Patient has had a trial on metronidazole or oral vancomycin? ☐ Yes ☐ No
3. **Alinia® suspension** (Length of Authorization: date of service)
 - ❖ Patient is ≥ 12 years old? ☐ Yes ☐ No
 - ❖ Diagnosis of diarrhea caused by *Cryptosporidium parvum* or *Giardia lamblia* ☐ Yes ☐ No
 - ❖ Patient has had a trial on metronidazole or oral vancomycin? ☐ Yes ☐ No
 - ❖ Patients < 12 years of age with diarrhea caused by *Cryptosporidium parvum* or *Giardia lamblia*, no trial on vancomycin or metronidazole required. ☐ Yes ☐ No
4. **Dificid®** (Length of Authorization: 10 days)
 - ❖ Patient is ≥ 6 months old? ☐ Yes ☐ No
 - ❖ Diagnosis of *C. difficile*? ☐ Yes ☐ No
 - ❖ 10-day trial of oral vancomycin? ☐ Yes ☐ No
5. **Neomycin (no preferred trial required)** (Length of Authorization: 1 year)
 - ❖ Patient diagnosed with hepatic coma? ☐ Yes ☐ No
 - ❖ Patient diagnosed with surgical (perioperative) prophylaxis? ☐ Yes ☐ No
 - ❖ Patient diagnosed with hepatic encephalopathy? ☐ Yes ☐ No
6. **Xifaxan® 200 mg** (Length of Authorization: 1 month and Quantity Limit 9 tabs per claim)
 - ❖ Patient is ≥ 12 years old? ☐ Yes ☐ No
 - ❖ Diagnosed with travelers' diarrhea caused by noninvasive strains of *E. coli*? ☐ Yes ☐ No

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7. Xifaxan® 550mg

- ❖ Patient is **≥ 18 years** old? ☐ Yes ☐ No
- ❖ Diagnosed with: **(check applicable diagnosis below):**
 - ☐ Irritable bowel syndrome with diarrhea (IBS-D)? ☐ Yes ☐ No
 - ☐ Irritable bowel syndrome with diarrhea (IBS-D) and had chronic symptoms for at least 6 months? ☐ Yes ☐ No
 - ☐ **Initial Approval:** 550 TID for 14 days
 - ☐ **Reauthorization Approval:** 42 tablets/14 days, can be retreated up to two times with the same regimen. (Maximum Quantity Limit:126 tablets/365 days) ☐ Yes ☐ No
 - ☐ Hepatic encephalopathy (Quantity Limit: 2 tablets/day) ☐ Yes ☐ No
 - ☐ Trial and failure of lactulose 20 to 30g (30 - 45mL) 3 to 4 times daily ☐ Yes ☐ No

MEDICAL NECESSITY: Provide clinical evidence that the PREFERRED drugs will **NOT provide adequate benefit.**

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****