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		
❑ **Firvanq™**	❑ **metronidazole tab**	❑ **vancomycin cap**
Non-Preferred Drugs (Require a Prior Authorization)		
❑ **Aemcolo™**	❑ **Alinia®** ❑ **nitazoxanide** (generic Alinia®)	❑ **Dificid®**
❑ **Flagyl® cap/tab/ER**	❑ **metronidazole cap**	❑ **neomycin**
❑ **paromomycin**	❑ **Solosec™**	❑ **Tindamax®**
❑ **tinidazole**	❑ **Vancocin®**	❑ **vancomycin compounded oral soln kit**
❑ **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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

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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.

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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.*