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		
❑ **metronidazole tab** (250mg/500mg)	❑ **vancomycin cap**	❑ **vancomycin for reconstitution oral soln kit** (generic Firvanq™ soln)
Non-Preferred Drugs (Require a Prior Authorization)		
❑ **Aemcolo™**	❑ **Alinia®** ❑ **nitazoxanide** (generic Alinia®)	❑ **Dificid®**
❑ **Firvanq™ soln**	❑ **Flagyl® cap/ER**	❑ **Likmez™**
❑ **metronidazole 125mg**	❑ **metronidazole cap**	❑ **neomycin**
❑ **paromomycin**	❑ **Solosec®**	❑ **Tindamax®**
❑ **tinidazole**	❑ **Vancocin®**	❑ **Vowst™** (refer to Vowst PA form)

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 – <u>Quantity Limit</u>: 6 tabs per rolling 30 days** (Length of Authorization: date of service)
   - ❖ Member is ≥ **<u>12 years</u>** 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 **<u>1 to 11 years</u>** 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 < **<u>12 years</u>** 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 ≥ **<u>6 months</u>** old? ❑ Yes ❑ No
   - ❖ Diagnosis of C. difficile? ❑ Yes ❑ No
   - ❖ 10-day trial of oral vancomycin? ❑ Yes ❑ No
5. **<u>Neomycin</u> (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

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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.

***REVISED/UPDATED/REFORMATTED:** ~~6/30/2017; 8/29/2017; 12/4/2017; 8/20/2018; 11/21/2018; 6/20/2019; 6/29/2021; 4/6/2022;7/17/2023; 11/7/2023; 6/20/2025;~~ **10/20/2025**