HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Antibiotics - GI and Related Agents

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. The member is prescribed the Antibiotics, GI and Related Agent for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication.

☐ Yes ☐ No

Q2. The member is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q3. The member is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q4. The request is for Dificid (fidaxomicin) for the treatment of Clostridioides difficile infection (CDI). If YES, go to 5. If NO, go to 8.

☐ Yes ☐ No

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Q5. The member has at least one of the following factors associated with a high risk for recurrence of CDI:

- ☐ a. Age 65 years,
- ☐ b. Clinically severe CDI (as defined by a Zar score 2),
- ☐ c. Is immunocompromised,

Q6. The member has a recurrent episode of CDI.

☐ Yes ☐ No

Q7. The member is prescribed Dificid (fidaxomicin) as a continuation of therapy upon inpatient discharge.

☐ Yes ☐ No

Q8. For the treatment of travelers' diarrhea, the member has a history of therapeutic failure of or a contraindication or an intolerance to azithromycin.

☐ Yes ☐ No

Q9. The request is for a preferred Antibiotics, GI and Related Agents.

☐ Yes ☐ No

Q10. For all other non-preferred Antibiotics, GI and Related Agents and for all other indications, the member has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antibiotics, GI and Related Agents approved or medically accepted for the beneficiary's diagnosis.

☐ Yes ☐ No

Q11. Additional Information:

Prescriber Signature

Date

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Member Name:	Prescriber Name:

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