HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

ANTIBIOTICS, GI and RELATED AGENTS PRIOR AUTHORIZATION FORM *(form effective 3/10/2025)*

Prior authorization guidelines for **Antibiotics, GI and Related Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/State/Zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For treatment of HEPATIC ENCEPHALOPATHY:
☐Has a history of trial and failure of or a contraindication or an intolerance to lactulose

2. For treatment of TRAVELERS' DIARRHEA:
☐Has a history of trial and failure of or a contraindication or an intolerance to azithromycin

3. For treatment of IRRITABLE BOWEL SYNDROME WITH DIARRHEA:
☐Requested medication is prescribed by or in consultation with a gastroenterologist

4. For treatment of SMALL INTENSTINAL BACTERIAL OVERGROWTH:
☐Requested medication is prescribed by or in consultation with a gastroenterologist

5. For DIFICID (FIDAXOMICIN) for treatment of *CLOSTRIDIOIDES DIFFICILE* INFECTION:
☐Has at least one of the following risk factors associated with a high risk of recurrence of *Clostridioides difficile* infection:
- ☐65 years of age or older
- ☐Clinically severe *Clostridioides difficile* infection (Zar score ≥2)
- ☐Immunocompromised status

☐Has a recurrent episode of *Clostridioides difficile* infection
☐Is prescribed Dificid (fidaxomicin) as a continuation of therapy upon inpatient discharge

6. For ALL OTHER NON-PREFERRED Antibiotics, GI and Related Agents and for ALL OTHER INDICATIONS:

☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Antibiotics, GI and Related Agents that are approved or medically accepted for the treatment of the beneficiary's diagnosis

RENEWAL requests

1. For treatment of IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D):

☐ Had a successful initial treatment course
☐ Is experiencing recurrence of IBS-D symptoms
☐ Requested medication is prescribed by or in consultation with a gastroenterologist
☐ **Request is for XIFAXAN (RIFAXIMIN) and:**
  ☐ Has not received 3 or more treatment courses of Xifaxan (rifaximin) in the beneficiary's lifetime

2. For treatment of SMALL INTESTINAL BACTERIAL OVERGROWTH:

☐ Requested medication is prescribed by or in consultation with a gastroenterologist

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712

Prescriber Signature:	**Date**: