Health Partners Plans

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.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient 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. Is the requested drug prescribed for the treatment of a diagnosis that is indicated in the Food and Drug Administration (FDA) approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q2. Is the patient prescribed a dose and duration of therapy that is consistent with Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q3. Is the requested drug age-appropriate for the patient according to Food and Drug Administration (FDA) approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is this a request for Xifaxan (rifaximin)?

☐ Yes ☐ No

Q5. Is the requested drug being prescribed for travelers' diarrhea?

☐ Yes ☐ No

Q6. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of azithromycin?

☐ Yes ☐ No

Q7. Is the requested drug being prescribed for the treatment of hepatic encephalopathy?

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☐ Yes ☐ No

Q8. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of lactulose?

☐ Yes ☐ No

Q9. Is the requested drug being prescribed for irritable bowel syndrome with diarrhea (IBS-D)?

☐ Yes ☐ No

Q10. Is this a request for a renewal of authorization?

☐ Yes ☐ No

Q11. Does the patient have documentation of a successful initial treatment course with Xifaxan (rifaximin)?

☐ Yes ☐ No

Q12. Does the patient have a documented recurrence of irritable bowel syndrome with diarrhea (IBS-D) symptoms?

☐ Yes ☐ No

Q13. Has the patient received 3 treatment courses with Xifaxan (rifaximin) in the patient's lifetime?

☐ Yes ☐ No

Q14. Is the requested drug being prescribed by or in consultation with a gastroenterologist?

☐ Yes ☐ No

Q15. Have other etiologies for chronic diarrhea been ruled out?

☐ Yes ☐ No

Q16. Does the patient have a documented history of therapeutic failure of ALL of the following: A) lactose, gluten, and artificial sweetener avoidance, B) a low fermentable oligosaccharide, disaccharide, and monosaccharide and polyols (FODMAP) diet?

☐ Yes ☐ No

Q17. Does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of loperamide AND a bile acid sequestrant?

☐ Yes ☐ No

Q18. Is this a request for Zinplava (bezlotoxumab)?

☐ Yes ☐ No

Q19. Is the requested drug prescribed by or in consultation with a gastroenterologist or an infectious disease

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specialist?

☐ Yes ☐ No

Q20. Does the patient have a recent stool test positive for toxigenic Clostridium difficile?

☐ Yes ☐ No

Q21. Does the patient have at least ONE of the risk factors associated with a high risk for recurrence of Clostridium difficile infection (CDI): A) the patient is 65 years of age or older, B) extended use of one or more systemic antibacterial drugs, C) clinically severe CDI (as defined by a Zar score of 2 or greater), D) at least one previous episode of CDI within the past 6 months, E) a documented history of at least two previous episodes of CDI, F) the patient is immunocompromised, G) the presence of a hypervirulent strain of CDI bacteria (ribotypes 027, 078, or 244)?

☐ Yes ☐ No

Q22. Is the patient receiving Zinplava (bezlotoxumab) in conjunction with an antibiotic regimen that is consistent with the standard of care for the treatment of Clostridium difficile infection (CDI)?

☐ Yes ☐ No

Q23. Has the patient received a prior course of treatment with Zinplava (bezlotoxumab)?

☐ Yes ☐ No

Q24. Does the patient have a history of congestive heart failure?

☐ Yes ☐ No

Q25. Has the prescriber provided documentation attesting that the benefit of therapy is expected to outweigh the risks?

☐ Yes ☐ No

Q26. Does the patient have a documented history of therapeutic failure, intolerance of, or contraindication to the preferred gastrointestinal and related agent antibiotic drugs (e.g., Alinia suspension, Firvanqsolution, metronidazole tablet, neomycin tablet, vancomycin capsule)?

☐ Yes ☐ No

Q27. Additional Information:

Prescriber Signature

Date

Updated for 2020