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 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

Q3. 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

Q4. For Dificid (fidaxomicin) for the treatment of Clostridioides difficile infection (CDI), one of the following:

Has at least one of the following factors associated with a high risk for recurrence of CDI:
- Age = 65 years
- Clinically severe CDI (as defined by a Zar score = 2)
- Is immunocompromised
- Has a recurrent episode of CDI
- Is prescribed Dificid (fidaxomicin) as a continuation of therapy upon inpatient discharge

☐ Yes ☐ No

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

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

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?

☐ 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. For treatment of IBS-D: Is the medication being prescribed by or in consultation with a gastroenterologist AND does the patient have a history of therapeutic failure of a low fermentable oligo-, di-, and monosaccharides and polyols (FODMAP) diet?

☐ Yes ☐ No

Q11. Is the request for Zinplava?

☐ Yes ☐ No

Q12. For Zinplava: Is the medication being prescribed by or in consultation with a gastroenterologist or an infectious disease specialist?

☐ Yes ☐ No

Q13. For Zinplava: Is there a recent stool test positive for toxigenic Clostridioides difficile?

☐ Yes ☐ No

Q14. For Zinplava: Does the patient have a high risk for recurrence of CDI with one of the following factors?
- Age greater than or equal to 65
- Extended use of one or more systemic antibacterial drugs
- Clinically severe CDI (as defined by a Zar score greater than 2)
- Is immunocompromised
- The presence of a hypervirulent strain of CDI bacteria (ribotypes 027, 078, or 244)

☐ Yes ☐ No

Q15. For Zinplava: is receiving this in confunction with an antibiotic regimen that is consistent with the standard of care for the treatment of CDI.

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q16. For Zinplava: has not received a prior course of treatment with Zinplava.

☐ Yes ☐ No

Q17. Is this a request for a renewal of authorization?

☐ Yes ☐ No

Q18. Does the patient have documentation of a successful initial treatment course?

☐ Yes ☐ No

Q19. Does the patient have a documented recurrence of irritable bowel syndrome with diarrhea (IBS-D) symptoms?

☐ Yes ☐ No

Q20. Has the patient received 3 treatment courses with Xifaxan (rifaximin) in the patient's lifetime? Yes

☐ Yes ☐ No

Q21. 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., , Firvanq solution, metronidazole tablet, neomycin tablet, tinidazole tablet, vancomycin capsule)?

☐ Yes ☐ No

Q22. Additional Information:

Q23. Requested Duration:

☐ 12 Months

Prescriber Signature

Date

Updated for 2022

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