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. 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 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 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: a. Has at least one of the following factors associated with a high risk for recurrence of CDI: Age greater than or equal to 65 years, clinically severe CDI (as defined by a Zar score greater than or equal to 2, OR is immunocompromised.b. Has a recurrent episode of CDI c. Is prescribed Dificid (fidaxomicin) as a continuation of therapy upon inpatient discharge?

☐ Yes ☐ No

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Q5. For the treatment of travelers' diarrhea, does the patient have a documented history of therapeutic failure, contraindication, or intolerance of azithromycin?

☐ Yes ☐ No

Q6. For the treatment of hepatic encephalopathy, does the patient have a documented history of therapeutic failure, contraindication to, or intolerance of lactulose?

☐ Yes ☐ No

Q7. For the treatment of irritable bowel syndrome with diarrhea (IBS-D) or small intestinal bacterial overgrowth (SIBO), is the medication being prescribed by or in consultation with a gastroenterologist?

☐ Yes ☐ No

Q8. Is the request for Zinplava?

☐ Yes ☐ No

Q9. For Zinplava: Is the medication being prescribed by or in consultation with a gastroenterologist or an infectious disease specialist?

☐ Yes ☐ No

Q10. For Zinplava: Is there a recent stool test positive for toxigenic Clostridioides difficile?

☐ Yes ☐ No

Q11. 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) - At least one previous episode of CDI within the past 6 months or a documented history of at least two previous episodes of CDI - Is immunocompromised - The presence of a hypervirulent strain of CDI bacteria (ribotypes 027, 078, or 244)

☐ Yes ☐ No

Q12. For Zinplava: is receiving this in conjunction with an antibiotic regimen that is consistent with the standard of care for the treatment of CDI.

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☐ Yes ☐ No

Q13. For Zinplava: has the patient not received a prior course of treatment with Zinplava.

☐ Yes ☐ No

Q14. Is this a request for a renewal of authorization?

☐ Yes ☐ No

Q15. For the treatment of irritable bowel syndrome with diarrhea (IBS-D) or small intestinal bacterial overgrowth (SIBO), is the medication being prescribed by or in consultation with a gastroenterologist?

☐ Yes ☐ No

Q16. For the treatment of irritable bowel syndrome with diarrhea (IBS-D), does the patient have documentation of a successful initial treatment course?

☐ Yes ☐ No

Q17. Does the patient have a documented recurrence of irritable bowel syndrome with diarrhea (IBS-D) symptoms?

☐ Yes ☐ No

Q18. For Xifaxan: has the patient received 3 treatment courses with Xifaxan (rifaximin) in the patient's lifetime?

☐ Yes ☐ No

Q19. For all other non-preferred Antibiotics, GI and Related Agents and for all other indications, does the patient have a history of trial and failure of, or a contraindication, or an intolerance to the preferred Antibiotics, GI and Related Agents (e.g., Firvanq solution, metronidazole tablet, neomycin tablet, tinidazole tablet, vancomycin capsule) that are approved or medically accepted for the treatment of the beneficiary's diagnosis?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q20. Additional Information:

Prescriber Signature

Date

v2025