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

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Antibiotics, GI and Related Agents** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html

☐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:	
Member name:		City/State/Zip:	
Member 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 member 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)

pa health & wellness

☐ 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 member'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 member'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 844-205-3386

Prescriber Signature:	**Date**:

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Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)