OPTIMA FAMILY CARE MEDALLION 4.0
PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay the authorization process.***

Drug Requested: ***Gastrointestinal (GI) Antibiotics (Non-Preferred)*** ***(MEDICAID)***

Non-Preferred Medication (requires PA)
Check applicable box below. If not checked, authorization process will be delayed.

❑ Alinia® tab (quantity limit: 6 tabs/30 dys)	❑ Alinia® susp	❑ Dificid®
❑ Flagyl® cap/tab/ER	❑ metronidazole cap	❑ neomycin
❑ Tindamax®	❑ tinidazole	❑ Xifaxan®
❑ vancomycin compounded oral soln kit	❑ Vancocin®	

DRUG INFORMATION: ***Complete all information below or authorization process will be delayed.***

Drug Name/Form: _____ **Strength**: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable:*** _____

CLINICAL CRITERIA**: *Check below ALL that apply. Boxes must be checked to ensure the authorization process will NOT be delayed. Chart notes and lab results MUST be attached to this request.***

1) **Alinia® tablets** – ***Quantity Limit*****: *6 tabs per rolling 30 days (Length of Authorization: date of service)***
   - Patient is ≥ **12** years of age? ❑ Yes ❑ No
   - Diagnosis of diarrhea caused by Cryptosporidium parvum or Giardia lamblia, **AND** ❑ Yes ❑ No
   - Patient has had a trial on metronidazole or oral vancomycin? ❑ Yes ❑ No

2) **Alinia® suspension** ***(Length of Authorization: date of service)***
   - Patient is ≥ **12** years of age? ❑ Yes ❑ No
   - Diagnosis of diarrhea caused by Cryptosporidium parvum or Giardia lamblia, **AND** ❑ Yes ❑ No
   - Patient has had a trial on metronidazole or oral vancomycin? ❑ Yes ❑ No
   - Patients **< 12 years** of age with diarrhea caused by Cryptosporidium parvum or Giardia lamblia, no trial on vancomycin or metronidazole required.

3) **Dificid®** ***(Length of Authorization: 30 dys)***
   - Patient is ≥ **17** years old? ❑ Yes ❑ No
   - Diagnosis of C. difficile, **AND** ❑ Yes ❑ No
   - 10-day trial of metronidazole or oral vancomycin? ❑ Yes ❑ No

4) **Neomycin** ***(no preferred trial required) (Length of Authorization: 1 yr)***
   - Patient diagnosed with hepatic coma? ❑ Yes ❑ No

5) **Xifaxan® 200 mg** ***(Length of Authorization: 3 dys)***
   - Patient is ≥ **12 years of age**? ❑ Yes ❑ No
   - Diagnosed with travelers' diarrhea caused by noninvasive strains of E. coli? ❑ Yes ❑ No

(continued on next page)

6) **Xifaxan® 550mg**

- Patient is **≥ 18 years of age?** ❑ Yes ❑ No
- Diagnosed with: (check applicable diagnosis below): irritable bowel syndrome with diarrhea (IBS-D)? ❑ Yes ❑ No
  - ❑ Irritable bowel syndrome with diarrhea (IBS-D) and had chronic symptoms for at least 6 months?
    - ❑ **Initial Approval**: 550 TID for 14 days
    - ❑ **Reauthorization Approval**: another 14 days only; has 4 months elapsed since last Xifaxan® dose?
  - ❑ Hepatic encephalopathy
    - Trial and failure of lactulose 20 to 30g (30 - 45mL) 3 to 4 times daily

MEDICAL NECESSITY: *Provide clinical evidence that* ***metronidazole or oral vancomycin*** *will* ***not*** *provide adequate benefit.*

_____

_____

_____

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED: 7/1/2018**