OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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.**

Gastrointestinal (GI) Antibiotics (Non-Preferred)

DRUG REQUESTED: **(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 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 qualify to ensure 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

(continued on next page)

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

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? ❑ Yes ❑ No
       - ❑ **Initial Approval**: 550 TID for 14 days
       - ❑ **Reauthorization Approval**: another 14 days only; has 4 months elapsed since last Xifaxan® dose? ❑ Yes ❑ No
     - ❑ 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:** ~~6/30/2017~~; ~~8/29/2017~~; ~~12/4/2017~~; **8/20/2018**