pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ZINPLAVA (bezlotoxumab) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antibiotics, GI and Related Agents** and **Quantity Limits/Daily Dose Limits** are available on the Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ☐Zinplava 1000 mg/40 ml injection vial		Quantity: _____ vials
Dose/directions:		Weight: _____ lbs / kg
Diagnosis *(submit documentation)*:		Dx codes (*required*):
Zinplava is part of the DHS Specialty Pharmacy Drug Program and is only available from of one of the two DHS specialty pharmacies – Walgreen's Specialty Pharmacy.		
1. Is Zinplava being prescribed by, or in consultation with, a gastroenterologist or an infectious disease specialist?	☐Yes ☐No	*If prescriber is not a gastroenterologist or infectious disease specialist, submit documentation of consultation.*
2. Does the beneficiary have a recent stool test that is positive for toxigenic *Clostridium difficile*?	☐Yes ☐No	*Submit documentation.*
3. Does the beneficiary have any of the following risk factors associated with a high risk of recurrence of *Clostridium difficile* infection? ☐65 years of age or older ☐extended use of one or more systemic antibacterial drugs ☐clinically severe *Clostridium difficile* infection ☐at least one previous episode of *Clostridium difficile* infection within the past 6 months ☐documented history of at least two previous episodes of *Clostridium difficile* infection ☐immunocompromised status ☐infected with a hypervirulent strain of *Clostridium difficile* (ribotypes 027, 078, or 244)	☐Yes ☐No	*Submit documentation.*
4. Will the beneficiary receive Zinplava in conjunction with an antibiotic regimen that is consistent with the standard of care for the treatment of *Clostridium difficile* infection (eg., metronidazole, vancomycin, or fidaxomicin)?	☐Yes ☐No	*Submit documentation of antibiotic treatment regimen.*
5. Did the beneficiary ever receive Zinplava in the past?	☐Yes – *Submit documentation supporting the use of more than 1 course of treatment with Zinplava.* ☐No	
6. Does the beneficiary have a history of congestive heart failure?	☐Yes – *Submit documentation attesting that the benefits of treatment with Zinplava is expected to outweigh the risks.* ☐No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: