

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 <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

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

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

Prescriber Signature:	Date:
------------------------------	--------------

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.