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 DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

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

CLINICAL INFORMATION

Drug requested: ☐Zinplava 1000 mg/40 ml injection vial ☐Zinplava _____	Quantity: _____ vials
Dose/directions:	Weight: _____ lbs / kg
Diagnosis *(submit documentation)*:	Dx codes (*required*):
Is Zinplava being prescribed by or in consultation with a gastroenterologist or an infectious disease specialist?	☐Yes ☐No *Submit documentation of consultation if applicable.*
Does the beneficiary have a recent stool test that is positive for toxigenic *Clostridioides difficile*?	☐Yes ☐No *Submit documentation.*
Does the beneficiary have any of the following risk factors associated with a high risk of recurrence of *Clostridioides difficile* infection? ☐65 years of age or older ☐Extended use of one or more systemic antibacterial drugs ☐Clinically severe *Clostridioides difficile* infection ☐At least one previous episode of *Clostridioides difficile* infection within the past 6 months ☐Documented history of at least two previous episodes of *Clostridioides difficile* infection ☐Immunocompromised status ☐Infected with a hypervirulent strain of *Clostridioides difficile* (ribotypes 027, 078, or 244)	☐Yes ☐No *Submit documentation.*
Will the beneficiary receive Zinplava in conjunction with an antibiotic regimen that is consistent with the standard of care for the treatment of *Clostridioides difficile* infection?	☐Yes ☐No *Submit documentation of antibiotic treatment regimen.*
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

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

Prescriber Signature:	Date: