UnitedHealthcare Community Plan

Antibiotics: Anti-Infective Agents, Oral - Washington

Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**

This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Clinical and Drug Specific Information

	ALL REQUESTS
□ **Yes** □ **No**	**Does the patient have any of the following diagnoses?** *(If yes, check which applies)* □ Prophylaxis of hepatic encephalopathy □ Irritable bowel syndrome with diarrhea (IBS-D) □ Infectious/traveler's diarrhea
	PROPHYLAXIS OF HEPATIC ENCEPHALOPATHY
□ **Yes** □ **No**	**Does the patient have a history of overt hepatic encephalopathy OR liver cirrhosis?**
□ **Yes** □ **No**	**Does the patient have any of the following?** □ Currently stabilized on and will continue to use lactulose at maximally tolerated dose *List start date and dose:* □ History of failure of lactulose at a maximally tolerated dose for at least 30 days, or contraindication or intolerance to lactulose *List trial dates or reason:*
□ **Yes** □ **No**	**Is there baseline documentation of serum ammonia?** *If yes, list serum ammonia levels:*
□ **Yes** □ **No**	**Was the most recent lab value(s) of serum ammonia provided?** *If yes, list serum ammonia levels:*
□ **Yes** □ **No**	**Is there documentation of an improvement in hepatic encephalopathy, such as any of the following?** *(If yes, check which applies)* □ Decrease in serum ammonia levels from baseline □ Improvements in mental status □ Decrease in hospitalizations or emergency department visits □ Other predefined clinical criteria as specified by the provider
	IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D)
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication, or intolerance to any prior therapies for the treatment of IBS-D?** *(If yes, check which applies and complete Section D above)* □ Antidiarrheal (e.g., loperamide) □ Antispasmodics (e.g., dicyclomine) □ Tricyclic antidepressants (e.g., amitriptyline)
□ **Yes** □ **No**	**Has the patient used more than 2 courses of treatment for IBS-D in their lifetime?**
□ **Yes** □ **No**	**Is there documentation of improvement in IBS-D related symptoms from the previous course(s) of treatment?** *If yes, list improvement:*
□ **Yes** □ **No**	**Is there documentation with rationale for continued use of rifaximin?** *If yes, list rationale:*
	INFECTIOUS/TRAVELER'S DIARRHEA
□ **Yes** □ **No**	**Is it confirmed that this episode (infection) of traveler's diarrhea is caused by non-invasive strains of E. coli?**
□ **Yes** □ **No**	**Has the patient failed prior antibiotic treatment for this episode, or has contraindication or intolerance to any of the following?** *(If yes, check which applies and complete Section D above)* □ Azithromycin □ Ciprofloxacin □ Levofloxacin

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□ Yes □ No	**Is there culture/sensitivity testing showing antibiotic resistance to any of the following?** □ Azithromycin □ Ciprofloxacin □ Levofloxacin
□ Yes □ No	**Has the patient previously failed rifaximin for the current episode?**
□ Yes □ No	**Is there culture/sensitivity testing showing no antibiotic resistance to rifaximin?**
□ Yes □ No	**Have all other treatment options been ruled out?**

Provider Signature: _____ Date: _____