Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Antibiotics, GI and Related Agents

A. Prescriptions That Require Prior Authorization

Prescriptions for Antibiotics, GI and Related Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Antibiotics, GI and Related Agent. See the Preferred Drug List (PDL) for the list of preferred Antibiotics, GI and Related Agents at: https://papdl.com/preferred-drug-list.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antibiotics, GI and Related Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Antibiotics, GI and Related Agent for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication; **AND**

2. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. For Dificid (fidaxomicin) for the treatment of *Clostridioides difficile* infection (CDI), **one** of the following:

   a. Has at least **one** of the following factors associated with a high risk for recurrence of CDI:

      i. Age ≥65 years,
      ii. Clinically severe CDI (as defined by a Zar score ≥2),
      iii. Is immunocompromised,

   b. Has a recurrent episode of CDI,

   c. Is prescribed Dificid (fidaxomicin) as a continuation of therapy upon inpatient discharge;

   AND

5. For the treatment of travelers' diarrhea, has a history of therapeutic failure of or a contraindication or an intolerance to azithromycin; **AND**

6. For all other non-preferred Antibiotics, GI and Related Agents and for all other indications, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antibiotics, GI and Related Agents approved or medically accepted for the beneficiary's diagnosis;

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Antibiotics, GI and Related Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

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ANTIBIOTICS, GI and RELATED AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

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

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Complete the section(s) below that apply to the beneficiary and this request.

Check all that apply and submit documentation for each item.

NOTE: XIFAXAN (rifaximin) TABLET is no longer a Medicaid-covered drug.

Bausch Health US, LLC ("BHC"), the manufacturer of Xifaxan, ceased participation the Medicaid Drug Rebate Program ("MDRP") effective October 1, 2025.

- Medicaid patients whose plans no longer provide coverage for our products may be eligible for single-source BHC pharmaceuticals through our Patient Assistance Program (PAP).
- To enroll, click on the "Application for Medicaid-Only Patients" link at https://www.bauschhealthpap.com/ or by calling 1-833-862-8727.

1. For treatment of TRAVELERS' DIARRHEA:

☐Has a history of trial and failure of or a contraindication or an intolerance to azithromycin

2. For DIFICID / FIDAXOMICIN for treatment of *CLOSTRIDIOIDES DIFFICILE* INFECTION:

☐Has at least one of the following risk factors associated with a high risk of recurrence of *Clostridioides difficile* infection:
- ☐65 years of age or older
- ☐Clinically severe *Clostridioides difficile* infection (Zar score ≥2)
- ☐Immunocompromised status

☐Has a recurrent episode of *Clostridioides difficile* infection

☐Is prescribed Dificid (fidaxomicin) as a continuation of therapy upon inpatient discharge

3. For ALL OTHER NON-PREFERRED Antibiotics, GI and Related Agents and for ALL OTHER indications:

☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Antibiotics, GI and Related Agents.
Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber Signature:	**Date**: