



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

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.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

|                                      |  |                   |                  |                  |
|--------------------------------------|--|-------------------|------------------|------------------|
| <input type="checkbox"/> New request | <input type="checkbox"/> 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 TO DHS – PHARMACY DIVISION**

**Prescriber Signature:**

**Date:**

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