

ZINPLAVA (bezlotoxumab) PRIOR AUTHORIZATION FORM (form effective 01/03/2022)

Prior authorization guidelines for **Antibiotics, GI and Related Agents** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at <https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger>

<input type="checkbox"/> New request	<input type="checkbox"/> 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: <input type="checkbox"/> Zinplava 1000 mg/40 ml injection vial <input type="checkbox"/> Zinplava _____	Quantity: _____ vials
Dose/directions:	Weight: _____ lbs / kg
Diagnosis (<i>submit documentation</i>):	Dx codes (<i>required</i>):
Is Zinplava being prescribed by or in consultation with a gastroenterologist or an infectious disease specialist?	<input type="checkbox"/> Yes <i>Submit documentation of consultation if applicable.</i> <input type="checkbox"/> No
Does the beneficiary have a recent stool test that is positive for toxigenic <i>Clostridioides difficile</i> ?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
Does the beneficiary have any of the following risk factors associated with a high risk of recurrence of <i>Clostridioides 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>Clostridioides difficile</i> infection <input type="checkbox"/> At least one previous episode of <i>Clostridioides difficile</i> infection within the past 6 months <input type="checkbox"/> Documented history of at least two previous episodes of <i>Clostridioides difficile</i> infection <input type="checkbox"/> Immunocompromised status <input type="checkbox"/> Infected with a hypervirulent strain of <i>Clostridioides difficile</i> (ribotypes 027, 078, or 244)	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
Will the beneficiary receive Zinplava in conjunction with an antibiotic regimen that is consistent with the standard of care for the treatment of <i>Clostridioides difficile</i> infection?	<input type="checkbox"/> Yes <i>Submit documentation of antibiotic treatment regimen.</i> <input type="checkbox"/> No
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

Please submit to PromptPA <https://ghp.promptpa.com> OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	Date:
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GHP Family Pharmacy Customer Service
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