South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
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ZINPLAVA PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code:	**HCPC Code:**	
Drug Name:	**Quantity:**	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
Note: *The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.*		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	

CRITERIA		
☐	**Medical records to support use of product are submitted**	
Initial Therapy (check one)	**Yes** ☐	**No** ☐
☐	The recipient is ≥ 12 months of age	
☐	Therapy is prescribed by or in consultation with a gastroenterologist or infectious disease specialist	
☐	The recipient has a confirmed diagnosis of CDI as evidenced by **both** of the following: ☐ Passage of 3 or more loose bowel movements in 24 or fewer hours ☐ A positive stool test for toxigenic Clostridium difficile collected no more than 10 days prior to scheduled infusion	
☐	The recipient is starting or is currently receiving appropriate antibiotic treatment for CDI for at least 10 days	
☐	Zinplava will be administered during antibacterial drug treatment for recipient's CDI	
☐	The recipient meets therapy qualifications as evidenced by **one** of the following classifications: ☐ Recipient has had one or more previous CDIs requiring treatment in the past 6 months ☐ Recipient is ≥ 65 years of age ☐ Recipient is immunocompromised ☐ Severe CDI (WBC > 15,000 cells/mL OR Serum creatinine ≥ 1.5 mg/dL)	
PHYSICIAN SIGNATURE – PROVIDER ONLY		
This form must be signed by a physician		
☐	I certify that the information given in this form is a true and accurate medical indication for the required product	
Name & Title (Printed):		**Specialty:**
Signature:		