GEORGIA MEDICAID FEE-FOR-SERVICE
ANTIBIOTICS, GI PA SUMMARY

<table>
<thead>
<tr>
<th>Preferred</th>
<th>Non-Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metronidazole tablets generic</td>
<td>Dificid (fidamoxicin)</td>
</tr>
<tr>
<td>Neomycin generic</td>
<td>Paromomycin generic</td>
</tr>
<tr>
<td>Vancomycin generic</td>
<td>Xifaxan (rifaximin)</td>
</tr>
</tbody>
</table>

LENGTH OF AUTHORIZATION: Varies

PA CRITERIA:

**Dificid**
- Approvable for members 6 months of age or older for the treatment of *Clostridioides* (*Clostridium*) difficile-associated diarrhea (*C. difficile*) who have nonfulminant disease
- **AND**
  - For severe cases, member must have experienced inadequate response, allergy, contraindication, drug-drug interaction, intolerable side effect or resistance to vancomycin
- **OR**
  - For nonsevere cases, member must have experienced inadequate response, allergies, contraindications, drug-drug interactions, intolerable side effects or resistance to metronidazole and vancomycin.
  - In addition for the oral suspension for members weighing 12.5 kg or more, the member must be unable to swallow solid oral dosage formulations (i.e., tablets).

**Paromomycin**
- Approvable for members with a diagnosis of intestinal amebiasis (*Dientamoeba fragilis, Entamoeba histolytica*) including asymptomatic intestinal colonization who have experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to metronidazole or tinidazole.
- Approvable for members 18 years of age or older a diagnosis of hepatic coma or hepatic encephalopathy when being used to suppress intestinal bacterial growth and the member has experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to neomycin.
- Approvable for members with a diagnosis of cryptosporidiosis (*Cryptosporidium parvum*) in human immunodeficiency virus (HIV)-infected patients when used in combination with antiretroviral therapy (ART), symptomatic treatment, rehydration and electrolyte replacement.

**Xifaxan**
- Approvable for members 12 years of age or older with a diagnosis of traveler’s diarrhea caused by noninvasive strains of *Escherichia coli* who have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to at least two of the following preferred products: ciprofloxacin, ofloxacin and azithromycin.
❖ Approvable for members 18 years of age or older with a diagnosis of hepatic encephalopathy who are taking lactulose or have experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to lactulose.
❖ Approvable for a diagnosis of irritable bowel syndrome with diarrhea in members 18 years of age or older who have experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to loperamide or alosetron (Lotronex).

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling OptumRx at 1-866-525-5827.

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL list.