Prior Authorization Request Form for
rifamycin **(Aemcolo)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 Please complete the clinical assessment:

1. Is the patient GREATER than or EQUAL to 18 years of age?	☐ Yes Proceed to question 2	☐ No Stop Coverage not approved
2. Does the patient have a diagnosis of traveler's diarrhea caused by noninvasive strains of Escherichia coli?	☐ Yes Proceed to Question 3	☐ No Stop Coverage not approved
3. Does the patient have diarrhea complicated by fever and/or bloody stool?	☐ Yes Stop Coverage not approved	☐ No Proceed to Question 4
4. Does the patient have diarrhea due to pathogens other than noninvasive strains of E. coli?	☐ Yes Stop Coverage not approved	☐ No Proceed to Question 5
5. Has the patient tried and failed a 3-day trial of ciprofloxacin?	☐ Yes Sign and date below	☐ No Proceed to Question 6
6. Has the patient tried and failed azithromycin?	☐ Yes Sign and date below	☐ No Proceed to Question 7
7. Does the patient have a contraindication to BOTH ciprofloxacin and azithromycin?	☐ Yes Sign and date below	☐ No Stop Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

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For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: