HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
ANTHELMINTICS
Albenza®, Alinia®, Biltricide®, Emverm®, Stromectol®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Which helminth species is being treated?
Please provide documentation

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Albenza® (albendazole), ☐ Alinia® (nitazoxanide), ☐ Emverm® (mebendazole),

Dosing/Frequency:_____

Questions	Yes	No	Comments/Notes
1. Is this request for an indication of pinworm?	☐	☐	
2. If the request is not for pinworm, is the requesting provider an infectious disease specialist or in consultation with one?	☐	☐	
3. Is the request being made in accordance to the product's FDA approved indications?	☐	☐	**Please provide documentation**
ALBENZA®			
1. If the member is infected with pinworm (enterobiasis), does documentation show trial and failure of pyrantel pamoate, unless contraindicated?	☐	☐	**Please provide documentation**
ALINIA®			
1. If the member has a diagnosis of giardiasis, does documentation show a trial and failure of metronidazole, unless contraindicated?	☐	☐	
EMVERM®			
1. Is the member 2 years of age or older?	☐	☐	
2. If the patient is infected with pinworm (enterobiasis), does documentation show a failure of multiple courses of pyrantel, unless contraindicated?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician's Signature:

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Policy PHARM- 004
Origination Date: 10/12/2018
Reviewed/Revised Date: 10/28/2020
Next Review Date: 10/28/2021
Current Effective Date: 11/01/2020