

UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Pivya (pivmecillinam)

Member and Medication Information	
* indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information	
* indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at 855-828-4992 , to prevent processing delays.	

Criteria for Approval: (All of the following criteria must be met)

1. Is the patient female and 18 years of age or older? ☐ Yes ☐ No
2. Does the patient have a diagnosis of Uncomplicated Urinary Tract Infection? ☐ Yes ☐ No
3. Does the provider attest that the patient does **NOT** show any signs of complicated infection, such as fever (>100.4°F), flank pain, or structural abnormalities of the urinary tract? ☐ Yes ☐ No
4. Has the patient tried and failed adequate empiric courses of at least 3 first-line antibiotics, unless contraindicated, including but not limited to nitrofurantoin, trimethoprim-sulfamethoxazole, fosfomycin, beta-lactams (e.g. amoxicillin-clavulanate, cephalexin), or fluoroquinolones (e.g. ciprofloxacin, levofloxacin) **OR** has culture and sensitivity testing indicating that the infection is resistant to all first-line treatments? ☐ Yes ☐ No

☐ First-line treatment trial details (medication, dose, duration, date): _____

☐ Culture shows resistance to all of the above Lab results page #: _____
5. Were culture and sensitivity tests performed, and do the results confirm that the infection is caused by an isolate that is susceptible to Pivya (*E.Coli*, *P.mirabilis*, or *S.saprophyticus*)? ☐ Yes ☐ No

Please provide test results Chart note page# _____
6. Is the requested dosing consistent with the FDA-approved dosing of 1 tablet by mouth, three times a day, for 3 to 7 days? ☐ Yes ☐ No

Initial Authorization: One course per episode

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PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Prescriber's Signature

Date

For ADA accommodation or assistance completing this form, please call us at 801-538-6155.