HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

ANTHELMINTICS

albendazole, Alinia®, Emverm®, nitazoxanide

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

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.

Preferred: ☐ albendazole, ☐ Emverm® (mebendazole), ☐ nitazoxanide
Non-preferred: ☐ Alinia® (nitazoxanide)

Dosing/Frequency:_____

Questions	Yes	No	Comments/Notes
ALBENDAZOLE			
1. Is the medication request for a quantity of #4 per 30 days for treatment of pinworms/roundworm?	☐	☐	**No prior authorization required**
2. For quantities more than #4 per 30 days, is the medication request made by an infectious disease specialist and used for a dose and indication that is FDA-approved, or that is established in the literature?	☐	☐	**Please provide documentation**
EMVERM®			
1. Is the request made by an infectious disease specialist?			
2. If the request is to treat pinworm (enterobiasis), does documentation show a trial and failure of over-the-counter pyrantel pamoate, unless contraindicated?	☐	☐	**Please provide documentation**
NITAZOXANIDE			
1. Is the requesting provider an infectious disease specialist?			

2. If the member has a diagnosis of giardiasis, does documentation show a trial and failure of metronidazole, unless contraindicated?	☐	☐	**Please provide documentation**
3. If the request is for the treatment of norovirus, is the requesting provider an infectious disease specialist or a transplant provider and is the member immunocompromised?	☐	☐	**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-CHIP-004
Origination Date: 07/01/2024
Reviewed/Revised Date: 06/11/2025
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