



## ANTIPROTOZOALS PA SUMMARY

<b>PREFERRED</b>	Alinia, Mepron, Metronidazole immediate-release tablets (250mg, 500mg), Metronidazole vaginal gel, Nebupent
<b>NON-PREFERRED</b>	Flagyl ER, Metronidazole 375mg capsules, Tindamax (brand or generic tinidazole)

**LENGTH OF AUTHORIZATION:** 1 month

### PA CRITERIA:

*For Flagyl ER or generic metronidazole 375mg*

- ❖ Prescriber must submit a written letter of medical necessity stating the reason(s) why the preferred product, generic metronidazole regular-release tablets (250mg or 500mg), are not appropriate for the member.

*For Tindamax (brand or generic tinidazole)*

- ❖ The following are approvable diagnoses:
  - Trichomoniasis
  - Bacterial vaginosis
  - Giardiasis
  - Intestinal amebiasis
  - Amebic liver abscess
- ❖ Member must have experienced ineffectiveness, allergies, contraindications, drug-drug interactions, or a history of intolerable side effects to metronidazole.
- ❖ If approved, the PA will be entered for brand-name Tindamax.

### EXCEPTIONS:

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

### PA AND APPEAL PROCESS:

- ❖ For online access to the PA process please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight the pharmacy link on the top right side of the page, and click on “prior approval process”.

### QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limit please go to [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal), highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.