SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: (Select drug below)

❑ **Dificid®** (fidaxomicin)	❑ **Dificid®** (fidaxomicin) **suspension**

FOR THE APPROVAL OF RECURRENT CLOSTRIDIUM DIFFICILE-ASSOCIATED DIARRHEA

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Authorization for medication will only be approved for the following course of therapy:

Adult Dosing	Dificid 200 mg twice daily for 10 days
Infants ≥ 6 months and Children ≤ 8 years old	16 mg/kg/dose twice daily for 10 days; maximum dose: 200 mg/dose • 4 to <7 kg: Oral: Oral suspension: 80 mg twice daily for 10 days. • 7 to <9 kg: Oral: Oral suspension: 120 mg twice daily for 10 days. • 9 to <12.5 kg: Oral: Oral suspension: 160 mg twice daily for 10 days. • ≥12.5 kg: Oral: Oral suspension, tablets: 200 mg twice daily for 10 days.

(Continued on next page)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Medication is being requested to complete the length of therapy started in an inpatient setting

  Days of therapy, and quantity required for completion: _____ days _____ tablets/mL

OR

All of the following criteria must be met:

- ❑ Medication must be prescribed by a hospitalist, internist or in consultation with **ONE** of the following **(please note)**:
  - ❑ Infectious Disease Specialist
  - ❑ Gastroenterologist Specialist

AND

- ❑ Member is 6 months of age or older

AND

- ❑ **FOR PEDIATRIC PATIENTS:** Member's weight must be submitted _____kg

AND

- ❑ Member must have had trial and failure of vancomycin 125 mg by mouth four times daily for 10 days, or prolonged taper and pulsed vancomycin, for an initial **C. difficile** episode treatment **(claim must be documented in pharmacy paid claims)**

  Date of initial **C. difficile** infection episode: _____

AND

- ❑ Member must be experiencing another infection following an initial infection episode of **C. difficile,** or symptoms from initial infection did not improve after initial treatment

AND

- ❑ Submission of positive stool toxin test for the **CURRENT** infection episode is required **(must attach lab results)**

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*