

AvMed

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 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: (Select drug below)

| | |
|--|--|
| <input type="checkbox"/> fidaxomicin (Dificid®) | <input type="checkbox"/> Dificid® (fidaxomicin) suspension |
|--|--|

FOR THE APPROVAL OF RECURRENT CLOSTRIDIUM DIFFICILE-ASSOCIATED DIARRHEA

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

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

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

| | |
|--|--|
| Adult Dosing | Dificid 200 mg twice daily for 10 days |
| Infants \geq 6 months and Children \leq 8 years old | 16 mg/kg/dose twice daily for 10 days; maximum dose: 200 mg/dose <ul style="list-style-type: none">• 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.• \geq12.5 kg: Oral: Oral suspension, tablets: 200 mg twice daily for 10 days. |

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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.****