OPTIMA HEALTH PLAN

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. Incomplete form will delay authorization process.***

Drug Requested: **Dificid®** (fidaxomicin)

DRUG INFORMATION: ***Complete information below. If incomplete, authorization process will be delayed.***

Drug Form/Strength: _____

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

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

RECOMMENDED DOSING: ***Dificid® 200mg twice daily for 10 days***

CLINICAL CRITERIA*:** ***Boxes MUST be checked below to qualify or authorization process will be delayed. Documentation of failure MUST be attached.

PRESCRIBED BY OR IN CONSULTATION WITH:

- Infectious Disease Specialist ❑ YES ❑ NO
- Gastroenterologist Specialist ❑ YES ❑ NO
- Virulent strain NAP1/BI/027 ❑ **YES** ❑ NO

TRIAL AND FAILURE OF METRONIDAZOLE AND VANCOMYCIN:

- Metronidazole 500mg q8 ❑ YES ❑ NO
- Vancocin PO 125mg QID ❑ YES ❑ NO

MEDICAL NECESSITY*:** ***Provide clinical documentation that the preferred drugs (metronidazole and vancomycin) failed and did not provide adequate benefit.

_____

_____

*****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.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 10/20/2011
***UPDATED/REVISED:** ~~12/28/2011; 4/5/2012; 10/30/2014; 5/21/2015; 12/27/2015; 12/16/2016;~~ **8/12/2017**