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)

****FOR THE APPROVAL OF RECURRENT CLOSTRIDIUM DIFFICILE-ASSOCIATED DIARRHEA****

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Form/Strength: _____

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

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

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

Dificid 200mg twice daily for 10 days

CLINICAL CRITERIA: The following criteria **MUST** be met. **ALL** boxes **must** be checked to qualify to ensure authorization will **NOT** be delayed. IF medical chart notes or lab results need to be submitted with this request, it needs to be included with this request.

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

AND

- ❑ Member must be at least 18 years old

AND

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

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

AND

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

AND

- ❑ Member must be experiencing a recurrent **C. difficile** infection **(A recurrence is defined as an episode of symptom onset with a positive stool toxin assay result, followed by another episode with positive stool toxin assay result in the 2-8 weeks)**

AND

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

AND

(continued on next page)

- ❑ Trial of prolonged taper and pulsed vancomycin must have been attempted:

  Example of Taper/Pulsed Dosing

  - Vancomycin 125mg 4 times per day for 10-14 days, then
  - Vancomycin 125mg 2 times per day for one week, then
  - Vancomycin 125mg once daily for one week, then
  - Vancomycin 125mg every 2-3 days for 2-8 weeks

  AND

- ❑ Chart notes documenting vancomycin failure despite compliance with therapy are required to be submitted (compliance to be verified by pharmacy paid claims)

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;~~ **6/21/2018**
REVISED/UPDATED: ~~12/28/2011; 4/5/2012; 10/30/2014; 5/21/2015; 12/27/2015; 12/16/2016; 8/12/2017;~~ **9/22/2018**