pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

DIFICID (fidaxomicin) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Antibiotics, GI and Related Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	☐Dificid tablet ☐Dificid suspension ☐Dificid _____	Strength:	Quantity:
Dose/directions:			
Diagnosis (*submit documentation*):		Dx codes (*required*):	

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐For treatment of *Clostridioides difficile* infection:

- ☐Is prescribed Dificid (fidaxomicin) as a continuation of therapy upon inpatient discharge
- ☐Has at least one of the following risk factors associated with a high risk of recurrence of *Clostridioides difficile* infection:
  - ☐65 years of age or older
  - ☐Clinically severe *Clostridioides difficile* infection (Zar score ≥2)
  - ☐Immunocompromised status
- ☐Had at least one previous episode of *Clostridioides difficile* infection

☐For treatment of any medical condition EXCEPT *Clostridioides difficile* infection:

- ☐Has a history of trial and failure of or contraindication or an intolerance to the preferred medications in this class that are approved or medically accepted for the diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.)*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: