

Dificid[®] Prior Authorization Request Form

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Member Information (required)			F	Provider Information (required)			
Member Name:			Provider Nam	Provider Name:			
Insurance ID#:			NPI#:	NPI#: Specialty:			
Date of Birth:			Office Phone	Office Phone:			
Street Address:			Office Fax:	Office Fax:			
City:	State:	Zip:	Office Street	Office Street Address:			
Phone:		City:	State:	Zip:			
Medication Information (required)							
Medication Name:			Strength:	Strength: Dosage Form:			
Check if requesting		Directions for	Directions for Use:				
Check if request is	of therapy						
Clinical Information (required)							
Select the diagnosis below:							
Clostridium difficile-associated diarrhea (CDAD)							
Other diagnos		ICD-10 Cod	ICD-10 Code(s):				
Clinical informat	ion:						
Has the patient been treated per the current guidelines? D Yes D No							
Select the following that the patient has failed:							
Initial episode (mild to moderate severity) – metronidazole							
Initial episode (severe) – vancomycin							
Initial episode (severe, complicated) – vancomycin and metronidazole							
First recurrence – same regimen as first episode							
Second recurrence – oral vancomycin in tapered regimen							

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received. For urgent or expedited requests please call 1-855-401-4262. This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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