

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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