PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

DIFICID PRIOR AUTHORIZATION FORM

PATIENT INFORMATION

Subscriber's ID Number		Subscriber's Group Number	
Patient's Name	Phone	Date of Birth	
Address	City	State	Zip Code

PRESCRIBER INFORMATION

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building	Physician's Signature	Date	

MEDICATION INFORMATION

Diagnosis:	
Quantity:	Day Supply:

CLINICAL CRITERIA

1. Does the patient have a diagnosis of CDAD (Clostridium difficile-associated diarrhea)?
   ☐ Yes ☐ No

   If **YES**:

   a. Has the patient experienced an episode of symptom onset (e.g. unexplained or new onset loose bowel movements)?
      ☐ Yes ☐ No

   b. Does the patient have at least 3 unexplained and new-onset loose bowel movements in less than 24 hours?
      ☐ Yes ☐ No

   c. Is there documentation of a positive nucleic acid amplification test (NAAT) or polymerase chain reaction (PCR) result for C. difficile?
      ☐ Yes ☐ No

   d. Is there documentation of a positive glutamate dehydrogenase (GDH) test result?
      ☐ Yes ☐ No

   e. Is there documentation of a positive enzyme immunoassay (EIA) for C. difficile toxin?
      ☐ Yes ☐ No

   f. Is there documentation of a positive stool culture for C. difficile?
      ☐ Yes ☐ No

2. Has the patient tried and failed Vancomycin?
   ☐ Yes ☐ No

3. Please provide any other medications previously tried and failed for the patient's diagnosis:

   _____

   _____

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **Clinical Services,**
   120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222