HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

CLOSTRIDIUM DIFFICILE DRUGS

Dificid®, Zinplava™

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Dificid® (fidaxomicin), ☐ Zinplava™ (bezlotuxumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
DIFICID®			
1. Does the member have a diagnosis of C. difficile based on diarrheal symptoms AND a current positive stool toxin test?	☐	☐	**Please provide documentation**
2. If this is for an initial episode, does documentation show a trial and failure of at least 10 days of oral vancomycin?	☐	☐	**Please provide documentation**
3. If the request is for recurrent C. difficile, does documentation show a trial and failure of pulsed or tapered vancomycin regimen OR a second 10-day course of vancomycin?	☐	☐	**Please provide documentation**
ZINPLAVA™			
1. Is the request for prophylaxis therapy with Zinplava™?	☐	☐	
2. Does the member have a diagnosis of C. difficile based on diarrheal symptoms AND a positive stool toxin test or PCR?	☐	☐	**Please provide documentation**
3. Has the member had at least 2 confirmed recurrent C. difficile episodes (3 total) that have been treated with a vancomycin regimen?	☐	☐	**Please provide documentation**
4. Does documentation show that the second recurrence was treated with pulsed or tapered vancomycin?	☐	☐	**Please provide documentation**
5. Will the member concurrently receive vancomycin or metronidazole?	☐	☐	
1. Is the member at high risk of C. difficile recurrence by meeting one of the following:	☐	☐	**Please provide documentation**

• Age ≥ 65 years • History of C. difficile infection in the past 6 months • Immunocompromised state • C. diff ribotype 027 6. Severe C. difficile infection at presentation with white blood cell ≥15,000 cells/mm^3 OR serum creatinine > 1.5g/dL			
REAUTHORIZATION			
1. Is the request for reauthorization of Dificid®?	☐	☐	
2. Does updated documentation show continued medical need and tolerance of therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-CHIP-015
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024