

**DIFICID PRIOR AUTHORIZATION REQUEST FORM**



**OptumRx**  
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Today's Date  
 /  /

**Note: This form must be completed by the prescribing provider.**

**\*\*All sections must be completed or the request will be returned\*\***

Patient's Medicaid # <input type="text"/>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>
Patient's Name	Prescriber's Name
Prescriber's IN License # <input type="text"/>	Specialty
Prescriber's NPI # <input type="text"/>	Prescriber's Signature
Return Fax # <input type="text"/> - <input type="text"/> - <input type="text"/>	Return Phone # <input type="text"/> - <input type="text"/> - <input type="text"/>
Check box if requesting retro-active PA <input type="checkbox"/>	Date(s) of service requested for retro-active eligibility (if applicable):

*Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).*

Requested Medication	Quantity	Dosing
<input type="checkbox"/> Dificid 200mg tablet		
<input type="checkbox"/> Dificid 200mg/5mL suspension		

**Dificid PA Requirements**

Does the member have a diagnosis of *clostridium difficile* infection (CDI)?  Yes  No

Is the member 6 months of age or older?  Yes  No

Is the member able to swallow tablet formulation?  Yes  No

**Please choose one of the following:**

Member has an initial episode of CDI and is at an increased risk of CDI recurrence

Please provide risk factor(s) for recurrence: \_\_\_\_\_

**-OR-**

Member has an initial episode of CDI and has a diagnosis of vancomycin-resistance pseudomembranous colitis (documentation required)

**-OR-**

Member has a recurrent episode of CDI

**\*Note: plan prefers brand name Dificid; requests for generic fidaxomicin will require generic medically necessary PA review**

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