HEALTH PLANS
UNIVERSITY OF UTAH

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 U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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:_____

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of C. diff based on diarrheal symptoms AND positive stool toxin test or PCR?	☐	☐	**Please provide documentation**
INITIAL EPISODE ADULT			
1. Is this an initial episode of C. diff in an adult?	☐	☐	
2. Does documentation show a trial and failure of at least 10 days of oral vancomycin?	☐	☐	**Please provide documentation**
INITIAL EPIDSODE PEDIATRIC			
1. Is this an initial episode of C. diff in a pediatric member (<18 years old)?	☐	☐	
2. Does documentation show a trial and failure of oral vancomycin or metronidazole?	☐	☐	**Please provide documentation**
RECURRENT C. diff INFECTION			
1. Is the request for recurrent C. diff infection?	☐	☐	**Please provide documentation**
2. Does documentation show at least one of the following: • A pulsed or tapered vancomycin regimen OR a second 10-day course has been trialed and failed • If metronidazole was used for primary episode, a standard 10-day course of vancomycin has been tried and failed	☐	☐	**Please provide documentation**
ZINPLAVA™			
1. Is the request for prophylaxis therapy with Zinplava™?	☐	☐	

2. Has the member had at least 2 confirmed recurrent C. Diff episodes (3 total)?	☐	☐	
3. Does documentation show that the second recurrence was treated with pulsed or tapered vancomycin?	☐	☐	
4. Will the member concurrently receive vancomycin or metronidazole?	☐	☐	

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:

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Policy PHARM-015
Origination Date: 02/14/2018
Reviewed/Revised Date: 03/25/2020
Next Review Date: 03/25/2021
Current Effective Date: 03/26/2020