

**INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
DIFICID® PRIOR AUTHORIZATION REQUEST FORM**



CareSource Pharmacy Prior Authorization Form

**P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019**

Today's Date

/ /

Non-Urgent ☐

Urgent ☐

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

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

Patient's CareSource # <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"/>	Office Contact
Prescriber's Fax <input type="text"/> - <input type="text"/> - <input type="text"/>	Prescriber's Phone <input type="text"/> - <input type="text"/> - <input type="text"/>
Prescriber's Address	Date(s) of Service: _____ Start Date: _____
Requested Medication	Quantity
<input type="checkbox"/> Dificid 200mg tablet <input type="checkbox"/> Dificid 200mg/5mL suspension	
Directions for Use	

PA Requirements for Dificid:

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

Diagnosis Code: _____

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

I attest that the provided information above is accurate:

Physician Signature: _____ **Date:** _____

CONFIDENTIAL INFORMATION

This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at **1-844-607-2831**.