



The drug, Dificid (fidaxomicin, is subject to the prior authorization process.

## PROCEDURE

### Initial Authorization Criteria:

*Must meet all of the criteria listed under the respective header:*

#### 1. Automatic coverage:

- Must have documented claim history of prior therapy with vancomycin or oral metronidazole

#### 2. Members without claims history:

- Must submit chart documentation which shows the member has tried and failed, or has a contraindication to, or had intolerance to vancomycin or oral metronidazole

### Limitations:

| Length of Authorization (if above criteria met) |   |
|---|---|
| Initial Authorization                           | Up to duration of member's membership with plan |
| Reauthorization                                 | N/A   |

If the established criteria are not met, the request is referred to a Medical Director for review.

## REFERENCES

1. Dificid [package insert]. San Diego, CA: Optimer Pharmaceuticals, Inc; 2011.

## RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

## REVIEW HISTORY

| DESCRIPTION OF REVIEW / REVISION | DATE APPROVED       |
|----------------------------------|---------------------|
| <i>Annual review</i>             | <i>02/17, 02/18</i> |

