MHS PHARMACY BENEFIT
DIFICID® PRIOR AUTHORIZATION REQUEST FORM

MHS
550 N. Meridian St. Suite 101
Indianapolis, IN, 46204-1208
Phone: (877) 647-4848 Fax: (866) 399-0929

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 # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retroactive PA ☐	Date(s) of service requested for retroactive 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
☐ Dificid 200mg tablet ☐ 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