# PRIOR AUTHORIZATION REQUEST
## *Vancomycin Oral*

PATIENT: Name_____ Prescriber: Name_____
Address: _____ Address _____
City, State, Zip_____ City, State, Zip__
D.O.B. _____ Phone _____
Member ID:_____ Fax _____
NPI _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

**SECTION A** Please answer the following questions

1. What is the diagnosis or indication?
   - θ Enterocolitis caused by staphylococcus aureus (MSSA or MRSA) → ***please answer question 2***
   - θ C. difficile infection (CDI) associated diarrhea → ***please answer question 3***
   - θ All other diagnoses ***(Please specify)*** _____ _____
2. θ Yes θ No Has the patient's condition been confirmed by lab results that support the presence of a staphylococcus aureus culture?
3. Is this request for an initial episode or recurrent episode of CDI?
   - θ Initial → ***please answer question 8***
   - θ Recurrence → ***please answer question 4***
4. Is this request for a first or second recurrence of CDI?
   - θ First recurrence→ ***please answer questions 6, 7 & 15***
   - θ Second recurrence→ ***please answer questions 5 - 6 & 15***
   - θ All others ***(Please specify):***_____
5. θ Yes θ No Has the patient's CDI been confirmed by labs (for example: toxin enzyme immunoassay [EIA], nucleic acid amplification [NAAT])?
6. θ Yes θ No Does the patient have severe CDI? ***If YES, please proceed to question 15***
7. θ Yes θ No Was the patient previously treated with vancomycin and CDI was confirmed by labs (for example: toxin enzyme immunoassay [EIA], nucleic acid amplification [NAAT])?
8. Does the patient have mild-to-moderate or severe CDI?
   - θ Mild-to-moderate CDI → ***please answer questions 11-14***
   - θ Severe CDI → ***please answer questions 9-10, 15***

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**If you have any questions, call: 800-753-2851**

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9. θ Yes θ No Does the patient have severe CDI with white blood cells (WBCs) GREATER THAN 15,000 OR serum creatinine (Scr) GREATER THAN 1.5x normal? ***If YES, please proceed to question 15 AND If NO, please proceed to question 10***
10. θ Yes θ No Does the patient have complicated CDI with hypotension of shock, ileus, or megacolon? ***If YES, please proceed to question 15***
11. θ Yes θ No Is the patient intolerant or allergic to metronidazole?
12. θ Yes θ No Is the patient still symptomatic after a 7-day therapy with metronidazole?
13. θ Yes θ No Has the patient's condition been confirmed by lab testing [for example, toxin enzyme immunoassay (EIA), nucleic acid amplification (NAAT)]?
14. θ Yes θ No Is the patient pregnant or breastfeeding?
15. What is the duration of therapy? →***please specify:[_____]***

***Please document the diagnoses, symptoms, and/or any other information important to this review:***

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

**FAX COMPLETED FORM TO: 877-251-5896**

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

**Confidentiality:** The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.



**If you have any questions, call: 800-753-2851**