ALBERTA BLUE CROSS®

FIDAXOMICIN
SPECIAL AUTHORIZATION REQUEST FORM

Please complete all required sections to allow your request to be processed.

Patients may or may not meet eligibility requirements as established by Alberta Government-sponsored drug programs.

PATIENT INFORMATION				**COVERAGE TYPE**
PATIENT LAST NAME	FIRST NAME		INITIAL	☐ Alberta Blue Cross ☐ Alberta Human Services ☐ Other
BIRTH DATE (YYYY-MM-DD)	ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS	CITY	PROV	POSTAL CODE	ID/CLIENT/COVERAGE NUMBER

PRESCRIBER INFORMATION			
PRESCRIBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION
			☐ CPSA ☐ ACO ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other — REGISTRATION NUMBER
STREET ADDRESS			
CITY, PROVINCE			PHONE / FAX
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED

Special authorization criteria

For the treatment of:
1) C. difficile infection (CDI) where the patient has failed, or is intolerant of oral vancomycin; or
2) Patients with third or greater recurrence of CDI (ie. fourth or greater episode of CDI)

Note:
- Fidaxomicin should not be used as an add-on to existing therapy (metronidazole or vancomycin).
- Not studied in multiple recurrences or those with life-threatening or fulminant CDI, toxic megacolon or inflammatory bowel disease.

Special authorization coverage for fidaxomicin will be provided for one treatment course (10 days) plus one additional treatment course for an early relapse occurring within eight weeks of the start of the most recent fidaxomicin course.

New episode of CDI after eight weeks will require treatment with first line therapy before fidaxomicin coverage may be considered.

Please provide the following information for ALL requests

1) Indicate diagnosis ☐ Clostridium difficile infection (CDI) ☐ Other (specify) _____

2) Is this the third or greater recurrence of CDI (i.e. fourth or greater episode of CDI)? ☐ Yes ☐ No

3) **Re-treatment requests ONLY:** Please indicate if treatment is requested for ☐ an early relapse OR ☐ a new CDI episode

Note: a CDI episode occurring ≥ 8 weeks after a previous episode with no intermittent recurrence of symptoms would be considered a new CDI episode.

4) **Previous medications utilized**

☐ Oral vancomycin has been used

a) Provide start date of most recent course (YYYY-MM-DD) _____

b) Specify response ☐ Failure ☐ Intolerance ☐ Other (specify) _____

☐ Oral vancomycin has NOT been used. Please provide reason _____

Additional information relating to request

PRESCRIBER'S SIGNATURE	DATE	Please forward this request to
		▪ **Alberta Blue Cross, Clinical Drug Services** **10009-108 Street NW, Edmonton, Alberta T5J 3C5** ▪ **FAX**: **780-498-8384** in Edmonton • **1-877-828-4106** toll free all other areas

ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST