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 REGISTRATION NUMBER ☐ CARNA ☐ ADA+C ☐ ACP ☐ Other
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

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 108 Street, Edmonton AB T5J 3C5.

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