# Dificid® Enrollment Form

PRx

## PATIENT INFORMATION

Patient Name: ________________________________________
Date of Birth: ____ /____ / ____ ☐ Male ☐ Female
SSN: ____ -____ - ____
Address: ____________________________________________
City: ______________ State: _____ Zip: ________________

Phone: ( ____ ) - ____ - ________
Email: ___________________________________________
Preferred method of contact: ☐ Phone ☐ Email
Height: ________ in Weight: ________ lb Date: ____ /____ / ____
Allergies: Medications: (Please attach additional pages if necessary)

## PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: __________________ ID#: ________________________ Group #: ______________ RxBIN: _________ RxPCN: _________

## PRESCRIBER INFORMATION

Prescriber Name: _________________________________
Address: ________________________________________
City: ____________ State: _____ Zip: ______________
Contact: ________________________
Clinic/Hospital Affiliation: ____________________________

Phone: ( ____ ) - ____ - ________
Fax: ( ____ ) - ____ - ________
License #: ________________________
NPI #: ________________________
Medicaid Provider #: ________________________

DFCDRX-19-01

## CLINICAL CONSIDERATIONS

Diagnosis:
☐ A04.7 Enterocolitis due to Clostridium difficile
☐ Other: ______________

Is patient new to therapy?: ☐ Yes ☐ No
Diagnosis Date: ____ /____ / ____

History of therapies tried/failed & dates:
☐ Oral Vancomycin ____ /____ / ____
☐ Other: ____ /____ / ____

Immunization History
☐ Influenza
Date: ____ /____ / ____

Rx

| Medication | Dose/Strength | Directions | Quantity | Refills |
|---|---|---|---|---|
| **Dificid®** (fidaxomicin) | ☐ 200 mg tablet | ☐ Take one tablet by mouth twice daily for 10 days | 20 | |
| | | ☐ Other: | | |

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

**Prescriber's signature:** ________________________________ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

## SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____



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