STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

Dificid® (fidamoxicin)

Prior Authorization Request Form

Prior authorization requests for Dificid will be approved if the following criteria are met:

1. Diagnosis of *severe Clostridium difficile infection; **AND**
2. Prior treatment with vancomycin for ten (10) to fourteen (14) days with no response.

**Persistent diarrhea with unchanged clinical symptoms*

Treatment Regimens for *Clostridium difficile* Infections[3]

Infection Characteristics	Clinical Status	Treatment Regimen
Initial episode Mild to moderate severity	WBC 15,000 cells/mcL or lower **AND** SCr less than 1.5 times baseline	Metronidazole 500 mg PO tid x 10 to 14 days
Initial episode Severe	WBC 15,000 cells/mcL or greater **OR** SCr 1.5 times or greater versus baseline	Vancomycin 125 mg PO qid x 10 to 14 days
Initial episode Severe, complicated	WBC 15,000 cells/mcL or greater **OR** SCr 1.5 times or greater versus baseline with hypotension/shock, ileus, megacolon	Vancomycin 500 mg PO/NG qid x 10 to 14 days PLUS metronidazole 500 mg IV q8h If ileus, consider adding rectal vancomycin
First recurrence	---	Same regimen as first episode
Second recurrence	---	**Oral vancomycin in tapered regimen (see text below)

***Metronidazole is not recommended in these patients because of concern of cumulative neurotoxicity.*

WBC - white blood cell count, SCr - serum creatinine, PO - by mouth, NG - by nasogastric tube, tid - three times daily, qid - four times daily

Detail-Document; **Prescriber's Letter 2011; 18(7):270710**
Reviewed and Approved
DUR Board 11/16/2011