MASSACHUSETTS

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Pharmacy Medical Policy

# Dificid® (fidaxomicin)

## Table of Contents



## Policy Number: 700

BCBSA Reference Number: None

## Related Policies

- N/A

## Policy

### Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

**Note:** All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department at (800)366-7778 to request a prior authorization/formulary exception verbally. Patients must have pharmacy benefits under their subscriber certificates.

Please refer to the chart below for the formulary and step status of the medications affected by this policy.

| Drug | Formulary Information |
|---|---|
| | Standard |
| | Formulary Status |
| **Dificid**® (fidaxomicin) | Step Therapy Required |

**We may cover** Dificid® (fidaxomicin) for the treatment of Clostridium difficile when **all** of the following criteria are met[1]:

- Prior treatment or failure with vancomycin.

**Requests based exclusively on the use of samples will not meet coverage criteria for exception. Additional clinical information demonstrating medical necessity of the desired medication must be submitted by the requesting prescriber for review.

We do not cover Dificid® (fidaxomicin) for other conditions not listed above.

## CPT Codes / HCPCS Codes / ICD-9 Codes

*The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.*

*Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.*

### CPT Codes

There is no specific CPT code for this service.

## Individual Consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

## Prior Authorization Information

**Outpatient**

For services described in this policy, see below for products where prior authorization **IS REQUIRED** if the procedure is performed **outpatient**.

| | Outpatient |
|---|---|
| **Commercial Managed Care (HMO and POS)** | Prior authorization is **required**. |
| **Commercial PPO and Indemnity** | Prior authorization is **required**. |

## Policy History

| Date | Action |
|---|---|
| 4/2020 | Updated to remove Age edit with approval of expanded age to the label. |
| 12/2018 | Updated to remove the requirement of metronidazole per P & T Committee. |
| 6/2017 | Updated address for Pharmacy Operations. |
| 10/2014 | Implementation of Policy. |

## References


1. Prescribing Information. Cubist Pharmaceuticals, Lexington MA. 2011
2. Guidelines for Diagnosis, Treatment, and Prevention of *Clostridium diffi cile* Infections. *Am J Gastroenterol* 2013; 108:478–498; doi: 10.1038/ajg. 2013.4


## To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

http://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf