AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Dificid	Page:	1 of 2
Effective Date:	4/1/2024	Last Review Date:	3/2024

Applies to:	☐Illinois	☐Florida	☒Florida Kids
	☒New Jersey	☒Maryland	☐Michigan
	☒Pennsylvania Kids	☐Virginia	☐Texas

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Dificid (fidaxomicin) under the patient's prescription drug benefit.

Description:

Dificid is indicated in adult and pediatric patients aged 6 months and older for the treatment of C. difficile-associated diarrhea (CDAD).

Usage
To reduce the development of drug-resistant bacteria and maintain the effectiveness of Dificid and other antibacterial drugs, Dificid should be used only to treat infections that are proven or strongly suspected to be caused by *C. difficile*. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy.

Applicable Drug List:

Dificid 200mg tablet
Dificid 40mg/mL suspension

Policy/Guideline:

The requested drug will be covered with prior authorization when the following criteria are met:

- The patient has the diagnosis of *C. difficile*-associated diarrhea (CDAD) confirmed by a positive stool assay

AND

- The patient requires additional medication to complete a 10-day course of the requested drug for therapy that was initiated in the hospital
  OR
- The patient has experienced an inadequate treatment response to oral vancomycin
  OR
- The patient has experienced an intolerance to vancomycin
  OR
- The patient has a contraindication that would prohibit a trial of vancomycin
  OR
- The requested drug is being prescribed for a pediatric patient **AND**

- The patient has experienced an inadequate treatment response to oral metronidazole
  OR
- The patient has experienced an intolerance to metronidazole
  OR
- The patient has a contraindication that would prohibit a trial of metronidazole

Approval Duration and Quantity Restrictions:

Approval: 10 days

References:

1. Dificid [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; June 2022.
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3. Micromedex (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 10/30/2023).
4. McDonald L, Gerding D, Johnson S, et al. Clinical Practice Guidelines for *Clostridium difficile* Infection in Adults and Children: 2017 Update by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA). *Clinical Infectious Diseases* 2018:66 (7): e1-e48. https://doi.org/10.1093/cid/cix1085. Accessed September 26, 2022.
5. Johnson S, Lavergne V, Skinner A et al. Clinical Practice Guideline by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA): 2021 Focused Update Guidelines on Management of Clostridioides difficile Infection in Adults, *Clinical Infectious Diseases* 2021;73 (5): e1029–e1044. https://doi.org/10.1093/cid/ciab549. Accessed September 26, 2022.
6. Kelly CR, Fischer M, Allegretti JR, LaPlante K, et al. ACG Clinical Guidelines: Prevention, Diagnosis, and Treatment of Clostridioides difficile Infections. *Am J Gastroenterol.* 2021 Jun 1;116(6):1124-1147.