curexa Specialty Rx Services

Dificid®

toll free phone. 855.927.0390
toll free fax. 855.927.0392

Patient Information

Patient Name:		Date of Birth:	☐ Male ☐ Female
Address:	City:	State:	Zip:
Phone Number:	Alternate Phone Number:	Language:	
Social Security Number:	E-Mail:		
Allergies:			☐ NKDA
☐ Pick Up / Ship to: ☐ Patient ☐ Office ☐ Alternative Address:			

Insurance: Please fax copy of insurance card (front and back)

Prescriber Information

Practice Name:		Office Contact:	
Prescriber:		NPI:	DEA:
Practice Address:	City:	State:	Zip:
Phone Number:	Fax Number:		

Clinical Information

Diagnosis/ICD-10:	Date of diagnosis:	Is the patient new to therapy? ☐ Yes ☐ No
Prior Failed Medications:		

Prescription Information

Medication	Dose	Directions	Quantity	Refills
☐ Dificid® (fidaxomicin)	200 mg	Take one tablet by mouth twice daily for 10 days	20	
☐ Dificid® (fidaxomicin)	200 mg			

Prescriber Signature and Date (Please sign and date below)

_____ _____

Substitution Permissible Date Dispense as Written Date

☐ Check here to authorize Curexa™ and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf. "I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge"