



Prior Authorization Approval Criteria
Department of Pharmacy Services

Generic Name: vancomycin (oral)

Brand Name: Vancocin® HCL

Medication Class: antibiotic

FDA Approved Uses: For the treatment of staphylococcal enterocolitis and antibiotic associated pseudomembranous colitis caused by *C. difficile*

Usual Dose: 500 mg to 2 g orally in 3 to 4 divided doses for 7 to 10 days.

Duration of Therapy: 10 days – 14 days

Criteria for Use: *(bullet points below are all inclusive unless otherwise noted)*

- Failed or intolerant to metronidazole
- Clinically diagnosed staphylococcal enterocolitis

Or

- Clinically diagnosed antibiotic associated pseudomembranous colitis caused by *C. difficile*

Or

- Organism is resistant to metronidazole.

Or

- Metronidazole is contraindicated (concomitant alcohol intake, pregnancy, hypersensitivity).

Or

- Diarrhea is caused by *Staphylococcus aureus*.

Not approved if:

- Not clinically defined staphylococcal enterocolitis or pseudomembranous colitis caused by *C. difficile*.

Or

- Patient is naïve to metronidazole

P&T Approval: _____ Date: _____