SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Vowst™ (fecal microbiota spores, live-brpk)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Quantity Limit: 12 capsules (1 bottle) per 365 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member is 18 years of age or older; **AND**
- ❑ Member has a confirmed diagnosis of recurrent CDI with a total of ≥ 3 episodes of CDI within the past 12 months **(submit documentation or verify previous antibiotic paid claims within the past 60 days)**; **AND**
- ❑ Antibiotic treatment for recurrent CDI must be completed (10 days of treatment) 2 to 4 days prior to initiation of Vowst™ therapy (i.e., previous treatment with vancomycin, fidaxomicin, including a pulsed vancomycin regimen or Zinplava®) **AND**

(Continued on next page)

- ❑ Provider will instruct member to take 10 oz of magnesium citrate (or 250 mL polyethylene glycol electrolyte solution for patients with impaired kidney function) the evening prior to initiation of Vowst™ therapy; **AND**
- ❑ Member must **NOT** have an absolute neutrophil count (ANC) < 500 cells/mm^3, toxic megacolon, or small bowel ileus

Reauthorization: Coverage may **NOT** be renewed. Vowst is approved for one time use. Repeat administration has **NOT** been approved.

Medication being provided by Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****