**HEALTH PARTNERS PLANS**
***PRIOR AUTHORIZATION REQUEST FORM***

# Vowst - Non-PDL

**Phone: 215-991-4300** **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

| | | |
|---|---|---|
| Member Name: | Prescriber Name: | |
| HPP Member Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Member Primary Phone: | NPI: | *PA PROMISe ID:* |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Line of Business: ☐ Medicaid ☐ CHIP | *Specialty Pharmacy (if applicable):* | |
| **Drug Name:** | **Strength:** | |
| **Quantity:** | **Refills:** | |
| **Directions:** | | |
| **Diagnosis Code:** | **Diagnosis:** | |

*HPP's maximum approval time is 12 months but may be less depending on the drug.*

**Please attach any pertinent medical history including labs and information for this member that may support approval.**
***Please answer the following questions and sign.***

Q1. Is the patient greater than or equal to 18 years of age?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of recurrent Clostridioides difficile infection (rCDI) as defined by both of the following:
a. Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for 2 consecutive days.
b. Positive stool test for confirming a Clostridioides difficile infection.

☐ Yes ☐ No

Q3. Did the patient experience one or more recurrences of CDI following an initial episode of CDI?

☐ Yes ☐ No

Q4. Did the patient receive antibiotic therapy for at least two episodes of CDI recurrence after the initial CDI episode?

☐ Yes ☐ No

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| Member Name: | Prescriber Name: |
|---|---|

Q5. Did the patient complete at least 10 days of one of the following antibiotic therapies for rCDI 2 to 4 days prior to initiating Vowst?
a. Oral vancomycin
b. Oral fidaxomicin

☐ Yes ☐ No

Q6. Is the previous episode of CDI is under control [e.g., less than 3 unformed/loose (i.e., Bristol Stool Scale type 6-7) stools/day for 2 consecutive days]?

☐ Yes ☐ No

Q7. Does the patient agree to drink magnesium citrate on the day before and at least 8 hours prior to taking the first dose of Vowst?

☐ Yes ☐ No

Q8. If the patient has a contraindication to magnesium citrate, was an alternative given based on medical judgment with documentation such as clinical notes?

☐ Yes ☐ No

Q9. Is the medication is prescribed by or in consultation with a gastroenterologist or infectious disease specialist?

☐ Yes ☐ No

Q10. Additional Information:

Prescriber Signature

Date

*v2025*