

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 Nam	e:	
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 Pharn	nacy (if applicable):	
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code: Diagnosi	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 24hour 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	

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



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

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document