Mountain Pacific
INNOVATING BETTER HEALTH
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Montana Healthcare Programs Prior Authorization Request Form for Use of Vowst® (fecal microbiota spores, live-brpk)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Medication is prescribed by or in consultation with: ☐ Gastroenterology ☐ Infectious Disease

   Action required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

   Name of specialist: _____ **Contact date:** _____
3. Member has a confirmed diagnosis of a second **recurrent** *Clostridioides difficile* infection (CDI) with a positive stool test for toxigenic *Clostridioides difficile* (*C. difficile*): ☐ Yes ☐ No
4. Member has been treated with standard of care antibiotics (fidaxomicin, vancomycin, metronidazole) for initial CDI and 2 recurrences (3 total episodes): ☐ Yes ☐ No

   Episode 1

   Drug name: _____ Date used: _____

   Episode 2

   Drug name: _____ Date used: _____

   Episode 3

   Drug name: _____ Date used: _____
5. Member has had a recurrent CDI episode within the last 6 months **OR** is at high risk for CDI recurrence, defined as any of the following:

   ☐ Age of 65 years or older
   ☐ Immunocompromised state
   ☐ Hypervirulent strain of *C. difficile* (i.e., ribotypes 027, 078, 244)
   ☐ Clinically severe CDI at presentation
   ☐ Date of last recurrent CDI episode in past 6 months: _____
6. Member has completed antibacterial treatment for recurrent CDI 2 to 4 days before initiating treatment with Vowst®: ☐ Yes ☐ No

7. Provider attests antibacterials will not be administered concurrently with Vowst®**:** ☐ Yes ☐ No
8. Provider attests the member has been informed of appropriate pre-treatment protocol**:**
    - ☐ If kidney function is unimpaired, drink 296ml (10oz) magnesium citrate on the day before and at least 8 hours prior to taking the first dose of Vowst®.
    - ☐ Do not eat or drink, except for small amounts of water, for at least 8 hours prior to taking the first dose.
9. Provider attests that, in members with decreased kidney function, provider has reviewed packaging information**:** ☐ Yes ☐ No ☐ N/A – Member unimpaired kidney function.

Limitations:

- Maximum daily dose: 4 capsules once daily for 3 days.
- Vowst® is not an antibacterial drug and should only be used 2 to 4 days after antibacterial drug creatment of CDI.

Initial authorization will be issued for a 3-day supply.
Therapy must be reauthorized for any additional CDI episodes.

☐ CONTINUATION OF THERAPY

1. Member has had laboratory confirmed recurrence of CDI within 8 weeks of an initial fecal microbiota treatment (FMT): ☐ Yes ☐ No
2. Member has completed antibacterial treatment for recurrent CDI 2 to 4 days before initiating treatment with Vowst®: ☐ Yes ☐ No
3. Specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A – Prescriber is a specialist.
4. Provider attests that member has been informed of appropriate pre-treatment protocol per packaging (see above): ☐ Yes ☐ No

Limitations:

Maximum daily dose: 4 capsules once daily for 3 days.

Reauthorization will be issued for a 3-day supply.
Therapy must be reauthorized for any additional CDI episodes.

Please complete form, including required attachments, and fax to:
Drug Prior Authorization Unit at 1-800-294-1350

10/2023