**NC Medicaid and NC Health Choice**
**Pharmacy Prior Approval Request for**
# Vowst

**Beneficiary Information**

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

**Prescriber Information**

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

**Drug Information**

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

## Clinical Information

**Coverage for Vowst:**

1. Is the beneficiary ≥ 18 years of age? ☐ **Yes** ☐ **No**

2. Does the beneficiary have a confirmed diagnosis of recurrent *Clostridioides difficile* infection (CDI) with a total of ≥3 episodes of CDI within 12 months? ☐ **Yes** ☐ **No**

3. Will antibiotic treatment for recurrent CDI be completed 2 to 4 days prior to initiation of Vowst therapy? ☐ **Yes** ☐ **No**

4. Will the beneficiary 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? ☐ **Yes** ☐ **No**

5. Is the beneficiary's absolute neutrophil count (ANC) ≥ 500 cells/mm3? ☐ **Yes** ☐ **No**

6. Does the beneficiary have toxic megacolon? ☐ **Yes** ☐ **No**

7. Does the beneficiary have small bowel ileus? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____
**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at (855) 710-1969
Pharmacy PA Call Center: (866) 246-8505