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 (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318