**PRIORITY PARTNERS**
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS
Vowst - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Vowst - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Vowst (fecal microbiota spores, live-brpk)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

**Diagnosis:** _____ **ICD Code:** _____

Comments: _____

**Please circle the appropriate answer for each question.**

1. Does the patient have a documented diagnosis of Clostridioides difficile infection (CDI)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If no, no further questions.]

2. Is there documentation the patient had a Clostridioides Y N _____

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| | difficile infection (CDI) episode 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, AND B) A positive stool test for Clostridioides difficile toxin? | | |
| | NOTE: Submission of medical records is required. | | |
| | [If no, no further questions.] | | |
| 3. | Has documentation been submitted showing the patient has had at least two recurrent episodes of CDI within 12 months (this is a total of 3 or more episodes of CDI including the initial infection)? | Y N | |
| | NOTE: Submission of medical records is required. | | |
| | [If no, no further questions.] | | |
| 4. | Has documentation been submitted showing the patient has had antibiotic therapy for at least two episodes of Clostridioides difficile infection (CDI) recurrence after the initial CDI episode? | Y N | |
| | NOTE: Submission of medical records is required. | | |
| | [If no, no further questions.] | | |
| 5. | Has documentation been submitted showing the patient has completed a 10 to 21-day treatment regimen with vancomycin or fidaxomicin with symptom resolution two to four days prior to starting prevention care with the requested medication? (Symptom resolution is defined as: less than 3 unformed stools in 24 hours for 2 or more consecutive days) | Y N | |
| | NOTE: Submission of medical records is required. | | |
| | [If no, no further questions.] | | |
| 6. | Has documentation been submitted showing the requested medication has been prescribed by, or has consulted with, a gastroenterologist or infectious disease specialist? | Y N | |
| | NOTE: Submission of medical records is required. | | |
| | [If no, no further questions.] | | |
| 7. | Is the patient 18 years of age or older? | Y N | |
| | [If no, no further questions.] | | |
| 8. | Will Vowst be used for any of the following: A) Treatment of Clostridioides difficile infection (CDI), B) Concurrent use with antibacterial products, OR C) Any indications or uses that are not FDA-approved or guideline-supported? | Y N | |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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| **Prescriber (Or Authorized) Signature and Date** |