TRICARE Prior Authorization Request Form for

fecal microbiota spores, live-brpk (Vowst)

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

Fax Completed Form and Applicable Progress Notes to:
(410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires after each fill. New PA is required for each treatment course.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID #: _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 year(s) of age?	☐ Yes Proceed to question **2**	☐ No Coverage not approved
2. Is the requested medication prescribed by or in consultation with a gastrointestinal or infectious disease specialist?	☐ Yes Proceed to question **3**	☐ No Coverage not approved
3. Has the patient had 3 or more episodes of Clostridioides difficile infection (CDI) within the last 12 months that is refractory to standard antibiotic therapy?	☐ Yes Proceed to question **4**	☐ No Coverage not approved
4. Is the patient's current episode of Clostridioides difficile infection controlled following 10 to 21 days of antibiotic therapy?	☐ Yes Proceed to question **5**	☐ No Coverage not approved
5. Has the patient had a positive stool test for Clostridioides difficile within 30 days?	☐ Yes Proceed to question **6**	☐ No Coverage not approved
6. Will the patient start therapy within 2 to 4 days following completion of antibiotic course for Clostridioides difficile treatment?	☐ Yes Proceed to question **7**	☐ No Coverage not approved
7. Will the patient undergo bowel cleanse using magnesium citrate or polyethylene glycol electrolyte solution on the day before the first dose of Vowst?	☐ Yes Sign and date below	☐ No Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: