AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Vowst

Beneficiary Information

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

Prescriber Information

7. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
8. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406