Trillium Health Resources
Pharmacy Prior Approval Request for

Vowst

Member Information

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

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name:_____ 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

1. Is the member ≥ 18 years of age? ☐ **Yes** ☐ **No**
2. Does the member 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 member 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 member's absolute neutrophil count (ANC) > 500 cells/mm3? ☐ **Yes** ☐ **No**
6. Does the member have toxic megacolon? ☐ **Yes** ☐ **No**
7. Does the member 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 PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277