Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Vowst - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Does the patient have active Clostridioides difficile infection (CDI)?

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Will Vowst be prescribed by, or in consultation with, a gastroenterologist or infectious disease specialist?

☐ Yes ☐ No

Q4. Is there documentation to confirm Vowst is being used to prevent the recurrence of CDI?

☐ Yes ☐ No

Q5. Has the patient experienced at least 2 recurrent CDIs?

☐ Yes ☐ No

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Q6. The patient has or will complete CDI standard of care treatment (defined as 10-21 days of treatment with vancomycin and/or fidaxomicin) 2-4 days prior to initiating treatment with Vowst.

☐ Yes ☐ No

Q7. The patient has or will complete a bowel prep and will not eat or drink for at least 8 hours prior to the first dose.

☐ Yes ☐ No

Q8. Requested Duration:

☐ 30 days ☐ Other

Q9. Additional Information:

_____ _____

Prescriber Signature Date

v2025