US Family Health Plan
Prior Authorization Request Form for
fecal microbiota spores, live-brpk (**Vowst**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Medical documentation may be required. Failure to provide could result in denial.

Prior authorization expires after one approval. 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. Has the patient had a positive stool test for Clostridioides difficile within 30 days?	☐ Yes Proceed to question **5**	☐ No Coverage not approved
5. Will the patient start therapy within 2 to 4 days following completion of antibiotic course for Clostridioides difficile treatment?	☐ Yes Proceed to question **6**	☐ No Coverage not approved
6. 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 _____

[30 June 2023]