Prescriber Criteria Form Vowst 2025 PA Fax 5993-A v2 010125.docx Vowst (fecal microbiota spores, live-brpk) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Vowst (fecal microbiota spores, live-brpk).

Drug Name: Vowst (fecal microbiota spores, live-brpk)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the prevention of recurrence of Clostridioides difficile infection (CDI)? [If no, then no further questions.]	Yes ◯	No ◯
2	Has the diagnosis of Clostridioides difficile infection (CDI) been confirmed by a positive stool test for C. difficile toxin? [If no, then no further questions.]	Yes ◯	No ◯
3	Will the requested drug be administered at least 48 hours after the last dose of antibiotics used for the treatment of recurrent Clostridioides difficile infection (CDI)? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the patient 18 years of age or older?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____