



**MEDICAID / CHIP**  
**PHARMACY PRIOR AUTHORIZATION REQUEST FORM**

**Vowst - Non-PDL**

Phone: 866-841-7659

Fax back to: 866-240-3712

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 ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	PA PROMISe ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):	
Drug Name:	Strength:	
Quantity:	Refills:	
Directions:		
Diagnosis Code:	Diagnosis:	

*Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..*

**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. Is the patient greater than or equal to 18 years of age?

Yes

No

Q2. Does the patient have a diagnosis of recurrent Clostridioides difficile infection (rCDI) as defined by both of the following:

a. Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for 2 consecutive days.

b. Positive stool test for confirming a Clostridioides difficile infection.

Yes

No

Q3. Did the patient experience one or more recurrences of CDI following an initial episode of CDI?

Yes

No

Q4. Did the patient receive antibiotic therapy for at least two episodes of CDI recurrence after the initial CDI episode?

Yes

No



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Q5. Did the patient complete at least 10 days of one of the following antibiotic therapies for rCDI 2 to 4 days prior to initiating Vowst?

- a. Oral vancomycin
- b. Oral fidaxomicin

Yes

No

Q6. Is the previous episode of CDI is under control [e.g., less than 3 unformed/loose (i.e., Bristol Stool Scale type 6-7) stools/day for 2 consecutive days]?

Yes

No

Q7. Does the patient agree to drink magnesium citrate on the day before and at least 8 hours prior to taking the first dose of Vowst?

Yes

No

Q8. If the patient has a contraindication to magnesium citrate, was an alternative given based on medical judgment with documentation such as clinical notes?

Yes

No

Q9. Is the medication is prescribed by or in consultation with a gastroenterologist or infectious disease specialist?

Yes

No

Q10. Additional Information:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

v2026-06