

VOWST

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:

- Recurrent Clostridioides difficile infection (CDI)
- Other (ICD code and description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? Yes No
2. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
If yes, please specify FDA labeled contraindication(s): _____
3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., infectious disease, gastroenterologist) or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
4. Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
If no, please provide rationale in support of using the requested agent for the patient's age for the requested indication: _____

For recurrent Clostridioides difficile infection (CDI) requests:

5. Will the requested agent be used to prevent the recurrence of Clostridioides difficile infection (CDI)? Yes No
6. Please select all that apply regarding the patient's diagnosis:
 - Greater than or equal to 3 episodes of CDI in a 12 month period
 - A positive C. difficile stool sample
 - A CDI episode of diarrhea greater than or equal to 3 unformed stools per day for at least 2 consecutive days
7. Has the patient completed a standard of care oral antibiotic regimen (e.g., vancomycin, fidaxomicin) for recurrent CDI at least 2 to 4 days before initiating treatment with the requested agent? Yes No

Please continue to the next page

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>8. Has the patient had an adequate clinical response to a standard of care oral antibiotic regimen (e.g., vancomycin, fidaxomicin) as defined by less than 3 unformed stools in 24 hours for 2 or more consecutive days?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Will the patient be using the requested agent in combination with any antibiotic regimen for any indication?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121</p> <p>TOLL FREE</p>		<p>CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.</p>	
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