



STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

FECAL MICROBIOTA CAPSULE

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
FECAL MICROBIO SPORE, LIVE-BRPK	VOWST	48888		GPI-10 (5252202010)	

GUIDELINES FOR USE

1. Is the request for the prevention of recurrent *Clostridioides difficile* infection (CDI) **AND** the patient meets the following criterion?

- The patient is 18 years of age or older

If yes, continue to #2.

If no, do not approve.

DENIAL TEXT: See the denial text at the end of the guideline.

2. Has the patient previously received Vowst?

If yes, continue to #4.

If no, continue to #3.

3. Has the patient completed antibiotic treatment (e.g., vancomycin [Vancocin], fidaxomicin [Dificid]) for recurrent CDI (defined as at least 3 CDI episodes)?

If yes, **approve for 30 days by HICL or GPI-10 for 1 fill with a quantity limit of #12 per 3 days.**

If no, do not approve.

DENIAL TEXT: See the denial text at the end of the guideline.

4. Does the patient meet **ALL** of the following criteria?

- The patient had treatment failure, defined as the presence of CDI diarrhea within 8 weeks of the first dose of Vowst, **AND** a positive stool test for *C. difficile*
- The patient has not previously received more than 1 treatment course of Vowst **AND** the start of that treatment course was at least 12 days and not more than 8 weeks prior

If yes, **approve for 30 days by HICL or GPI-10 for 1 fill with a quantity limit of #12 per 3 days.**

If no, do not approve.

DENIAL TEXT: See the denial text at the end of the guideline.

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GUIDELINES FOR USE

DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **FECAL MICROBIOTA CAPSULE (Vowst)** requires the following rule(s) be met for approval:

- A. You are using the requested medication for the prevention of recurrent *Clostridioides difficile* (*C. difficile*) infection (CDI: a bacterial infection)
- B. You are 18 years of age or older
- C. **If you have NOT previously received Vowst, approval also requires:**
 - 1. You have completed antibiotic (such as vancomycin [Vancocin], fidaxomicin [Dificid]) treatment for recurrent CDI (defined as at least 3 CDI episodes)
- D. **If you have been previously treated with Vowst, approval also requires:**
 - 1. You had treatment failure, defined as the presence of CDI diarrhea within 8 weeks of the first dose of Vowst, AND a positive stool test for *C. difficile*
 - 2. You have not previously received more than 1 treatment course of Vowst AND the start of that treatment course was at least 12 days and not more than 8 weeks prior

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Vowst.

REFERENCES

- Vowst [Prescribing Information]. Cambridge, MA: Seres Therapeutics, Inc.; April 2023.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A

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