Clinical Policy: Fecal Microbiota Spores, Live-brpk (Vowst)

Reference Number: CP.PHAR.632
Effective Date: 09.01.23
Last Review Date: 08.23
Line of Business: Commercial, HIM, Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Fecal microbiota spores, live-brpk (Vowst™) is a bacterial spore suspension in capsules manufactured from human fecal matter sourced from qualified donors.

FDA Approved Indication(s)

Vowst is indicated to prevention the recurrence of *Clostridioides difficile* infection (CDI) in individuals 18 years of age and older following antibacterial treatment for recurrent CDI.

Limitation(s) of use: Vowst is not indicated for treatment of CDI.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Vowst is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Prevention of *Clostridioides difficile* Infection (must meet all)**:**

1. Diagnosis of CDI confirmed by documentation of positive *Clostridioides difficile* test;
2. Age ≥ 18 years;
3. Member has recurrent CDI as evidenced by at least 2 episodes of CDI recurrence after a primary episode (i.e., total 3 episodes);
4. Member has received at least 10 consecutive days of antibiotic therapy for the current CDI (e.g., vancomycin, fidaxomicin);
5. The current CDI is controlled (< 3 unformed/loose stools/day for 2 consecutive days [i.e., diarrhea, or Bristol Stool Scale type 6-7]);
6. Vowst is prescribed with one of the following (a or b), administered prior to the first Vowst dose:
   a. Magnesium citrate;
   b. If member has impaired kidney function, polyethylene glycol electrolyte solution (e.g., generic GoLYTELY®);
7. Member has not previously received Vowst, Rebyota™, or prior fecal microbiota transplant;
8. Dose does not exceed 4 capsules per day for 3 consecutive days.

Approval duration: 3 months (1 treatment course only)

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Prevention of *Clostridioides difficile* Infection
1. Re-authorization is not permitted as the efficacy of repeat courses of Vowst has not been sufficiently established (*see Appendix D*).

Approval duration: Not applicable

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 2 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies –

CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
CDI: *Clostridioides difficile* infection
FDA: Food and Drug Administration
IDSA: Infectious Diseases Society of America

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Dificid® (fidaxomicin)	200 mg PO BID for 10 days; for recurrences, may use alternative regimen of 200 mg PO BID for 5 days, followed by QOD for 20 days	See regimen
vancomycin	125 mg PO QID for 10 days; for recurrences, may use a tapered and pulsed regimen	See regimen

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information
- Both the Infectious Diseases Society of America (IDSA) and the American College of Gastroenterology recommend fecal microbiota transplantation for patients experiencing their second or further recurrence of CDI.
- Approximately 35% of CDI patients experience recurrence after the initial treatment and resolution of diarrhea. Of those who have a primary recurrence, 40% will have another CDI episode, and after 2 recurrences, the chance of an additional episode increases to as high as 65%.
- Per the 2017 IDSA Clinical Practice Guidelines for CDI:
  - An incident case is one with a new primary symptom onset (i.e., in the previous 8 weeks, there was not an episode of positive symptoms with positive *Clostridioides difficile* result) and positive *Clostridioides difficile* assay result.
  - A recurrent infection is an episode of symptom onset with a positive assay result following an episode with positive assay result in the previous 2-8 weeks.
- Per the 2021 IDSA Focused Update for CDI in Adults:
  - Fidaxomicin is the preferred first-line treatment for patients with recurrent CDI episodes.
  - Vancomycin (in a tapered and pulsed regimen or as a standard course) is an alternative treatment for CDI recurrence.

- Bezlotoxumab (Zinplava®) is an adjunctive treatment that may be used in addition to standard of care antibiotics for patients with a recurrent CDI episode within the last 6 months.
- Prior to fecal microbiota transplantation, appropriate antibiotic treatments for at least 2 recurrences (i.e., 3 CDI episodes) should be tried.
- Examples of treatment regimens for recurrence:
  - Vancomycin 125 mg PO QID for 10 days (may be followed by rifaximin 400 mg PO TID for 20 days)
  - Tapered and pulsed regimens of vancomycin (e.g., vancomycin PO 125 mg QID for 10 to 14 days, then BID for 1 week, then QD for 1 week, then every 2 or 3 days for 2 to 8 weeks)
  - Fidaxomicin 200 mg PO BID for 10 days
  - Fidaxomicin 200 mg PO BID for 5 days followed by once every other day for 20 days
  - Fecal microbiota transplantation
  - Bezlotoxumab 10 mg/kg IV once during administration of standard of care antibiotics

- The Bristol Stool Scale is a tool to define stool types. Types 1-2 indicate constipated stool. Types 6-7 indicate diarrheal stool.
  - Type 1: separate hard lumps, like nuts
  - Type 2: sausage-shaped but lumpy
  - Type 3: like a sausage but with cracks on its surface
  - Type 4: like a sausage or snake, smooth and soft
  - Type 5: soft blobs with clear-cut edges (passed easily)
  - Type 6: fluffy pieces with ragged edges, a mushy stool
  - Type 7: watery, no solid pieces (entirely liquid)
- Repeat courses: In the event of treatment failure (i.e., CDI diarrhea) within the first 8 weeks of blinded treatment, participants in the ECOSPOR III phase 3 study were allowed to receive an open-label second treatment course of Vowst. However, only 4/89 (4.5%) patients who received an initial course of Vowst received this second course. All 4 of these patients ultimately achieved treatment success as week 8 and 12. At week 24, one of the 4 patients experienced a recurrence. Given that this was an open-label treatment and included a relatively small sample, this is considered insufficient data to support a second treatment course at this time.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Prevention of CDI	4 capsules PO QD for 3 consecutive days Prior to taking the first Vowst dose: • Complete antibacterial treatment for recurrent CDI 2 to 4 days before initiating treatment with Vowst • Drink 296 mL (10 oz) of magnesium citrate on the day before and at least 8 hours prior to taking the first dose of Vowst. In clinical studies, participants with	See regimen

Indication	Dosing Regimen	Maximum Dose
	impaired kidney function received polyethylene glycol electrolyte solution (250 mL GoLYTELY)	

VI. Product Availability

Capsule (a single dose is 4 capsules)

VII. References

1. Vowst Prescribing Information. Cambridge, MA: Seres Therapeutics, Inc.; April 2023. Available at: www.vowst.com. Accessed May 10, 2023.
2. Feuerstadt P, Louie TJ, Lashner B, et al. SER-109, an Oral Microbiome Therapy for Recurrent Clostridioides difficile Infection. N Engl J Med. 2022 Jan 20; 386(3):220-229.
3. Sims MD, Khanna S, Feuerstadt P, et al. Safety and Tolerability of SER-109 as an Investigational Microbiome Therapeutic in Adults With Recurrent Clostridioides difficile Infection: A Phase 3, Open-Label, Single-Arm Trial. JAMA Netw Open. 2023 Feb 1; 6(2): e2255758.
4. Lessa FC, Mu Y, Bamber WM et al. Burden of *Clostridium difficile* infection in the United States. N Engl J Med. 2015 Feb 26;372(9):825-34. doi: 10.1056/NEJMoa1408913
5. McDonald LC, Gerding DN, Johnson S, et al. Clinical practice guidelines for *Clostridium difficile* infection in adults and children: 2017 updated by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA). Clin Infect Dis. March 2018;66(7):987-994.
6. Johnson S, Lavergne V, Skinner AM, et al. Clinical practice guideline by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA): 2021 focused update guidelines on management of *Clostridioides difficile* infection in Adults. CID 2021; 73 (1 September): e1029-1044.
7. Kelly CR, Fischer M, Allegretti JR, et al. ACG clinical guidelines: Prevention, diagnosis, and treatment of *Clostridioides difficile* infections. Am J Gastroenterol. 2021; 116: 1124 - 1147.
8. Caroff DA, Edelstein PH, Hamilton K, et al. The Bristol stool scale and its relationship to *Clostridium difficile* infection. J Clin Microbiol. 2014; 52(9): 3437-3439.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	05.10.23	08.23

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.