

# VOWST Voyage™ Support Program Enrollment Form and Prescription



Please fax completed form to 1-888-234-6987.

For assistance, please call 1-888-356-5444.

All fields marked with an asterisk (\*) are required.

Patient first name\* \_\_\_\_\_ Patient last name\* \_\_\_\_\_ Date of birth\* \_\_\_\_\_

## 1. DIAGNOSIS AND CLINICAL INFORMATION\*

A04.71 Enterocolitis due to *Clostridium difficile*, recurrent     A04.72 Enterocolitis due to *Clostridium difficile*, not specified as recurrent<sup>†</sup>     Other \_\_\_\_\_ (Please fill in)

Please select documentation included with form\*

Number of recurrences\*

Patient chart notes     PCR test     Toxin test

One     Two     Three or more

<sup>†</sup>Is not the initial episode.

## 2. ANTIBACTERIAL TREATMENT DETAILS

**It is recommended that VOWST be prescribed at the same time as antibacterial therapy to ensure patient receives VOWST in a timely manner.**

Antibacterial treatment start date\* \_\_\_\_\_ Day supply\* \_\_\_\_\_ Number of refills \_\_\_\_\_

## 3. PREFERRED SPECIALTY PHARMACY\*

Amber Specialty Pharmacy     Orsini Specialty Pharmacy     No preference

## 4. PRESCRIBER INFORMATION

Prescriber Name\* \_\_\_\_\_ Practice/Hospital name\* \_\_\_\_\_  
(Please print)

Practice address\* \_\_\_\_\_ City/State/Zip code\* \_\_\_\_\_

Prescriber NPI\* \_\_\_\_\_ Office contact name\* \_\_\_\_\_

Office contact phone\* \_\_\_\_\_ Office fax\* \_\_\_\_\_ Email address \_\_\_\_\_

Preferred contact method  Phone     Fax     Email

## 5. PRESCRIPTION INFORMATION

### VOWST

VOWST (fecal microbiota spores, live-brpk) capsules

1 dose = 4 capsules; QTY:12

Refills: 0

Directions: Take each dose (4 capsules) on an empty stomach prior to the first meal of the day for 3 days

### WELCOME KIT

Please select one\*

Patient to receive one(1) 10 oz. bottle of magnesium citrate saline laxative oral solution in the Welcome Kit provided at no cost

Patient using an alternative laxative option (not included in Welcome Kit)<sup>‡</sup>

<sup>†</sup>In clinical studies, participants with impaired kidney function received polyethylene glycol electrolyte solution (250 mL GoLYTELY®, not approved for this use)

## 6. COMPLETE STATEMENT OF MEDICAL NECESSITY AND CONSENT\*

By my signature, I certify that I am the healthcare professional who has prescribed the therapy identified in this form. I further certify that I have made an independent judgment that the above therapy is medically necessary, and that the information provided in this form is accurate to the best of my knowledge. I authorize Aimmune Therapeutics, Inc. (Aimmune), and its affiliates, agents, representatives, and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

By checking this box, I certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Aimmune and its employees or agents for purposes relating to Aimmune patient support programs, including, assisting the patient with benefits verification, prior authorization/appeals assistance, financial assistance resources and information, such as co-pay support or free drug programs, for which the patient may be eligible, and other support for VOWST. I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by, VOWST Voyage, and/or parties acting on their behalf using email, text message, a live operator, autodialer, or prerecorded voice at the telephone number(s) provided regarding the purposes described above and for other non-marketing purposes. I also give my permission to receive calls related to these services from Aimmune, VOWST Voyage, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

Prescriber signature (Dispense as Written) \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

Prescriber signature (Substitutions Permitted) \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

FOR PRESCRIBER  
\* REQUIRED FIELD

SIGN &  
DATE



I hereby authorize my healthcare prescribers, health plans, pharmacies, and their respective contractors and agents ("my healthcare organizations") to share my personal and health information ("my information") related to my Aimmune therapy with Aimmune Therapeutics, Inc., and its affiliates, agents, and contractors, (collectively, "Aimmune") as described below. I authorize my healthcare organizations to share my information with Aimmune in order for Aimmune to: (1) contact me or my healthcare organizations, or others I have identified, about my disease or treatment; (2) confirm my health plan eligibility and benefits, and determine whether I may be eligible for financial assistance programs; (3) provide me with reimbursement support; (4) engage with me for internal business purposes, including quality control, support-enhancing surveys and market research; (5) send me marketing information, offers, and educational materials related to *Clostridioides difficile* and/or Aimmune therapies, including VOWST Voyage; and (6) use and disclose my information for safety reasons or as required by law. I understand that if I do not sign this form, my treatment and payment for my treatment by my healthcare prescribers and pharmacy will not be affected, but I will not have access to the Aimmune support described above. I understand that my pharmacy providers and/or their contractors may receive financial remuneration from Aimmune for disclosing my information to Aimmune, and for providing support services to me, including sending me communications, pursuant to this authorization.

I understand that once my health information has been disclosed to Aimmune, federal privacy laws may no longer protect it and it may be further redislosed. I may cancel this authorization at any time by notifying Aimmune at 1-888-356-5444 or by sending written notice to P.O. Box 592188, Orlando, FL 32859 or [info@vowstsupport.com](mailto:info@vowstsupport.com). My cancellation will not be effective until after Aimmune receives it and my healthcare organizations are notified of it by Aimmune, and it will not apply to any of my information disclosed in reliance on this authorization prior to my cancellation. I am entitled to a copy of this signed authorization, which expires at the earlier of ten (10) years or other time period required under the state in which I reside, from the date it is signed by me.

## TELECOMMUNICATIONS OPT-IN (OPTIONAL)

Check here to receive nonmarketing tools and resources via calls/text messages from or on behalf of Amimmune and its affiliates at the telephone number(s) that I provide to help support me on my treatment journey with VOWST. I understand that these communications may be sent using an autodialer or artificial/prerecorded voice at the telephone number(s) that I provide. Message and data rate may apply. Recurring messages; frequency may vary.

If signed by a patient representative:

**SIGN**

— Date: \_\_\_\_\_

Signature of patient or patient representative

Printed name

Phone number of patient representative



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