Rebyota™

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Enterocolitis due to *Clostridium difficile*, recurrent, A04.71

☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Rebyota™ (fecal microbiota, live-jslm)	150 mL	Administer rectally via gravity over 3-5 minutes x 1 dose *Observe patient for 15 minutes following administration*

Has patient received therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of Last Treatment: _____ Date of Next Treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Promethazine 25mg PO ☐ Ondansetron 4mg PO/IV

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ Blood glucose q _____ ☐ CBC with diff/platelet q _____

☐ CMP q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

☐ H&P indicates clear evidence of recurrent *C. difficile* infection (CDI).

- Number of previous CDI episode(s) within the last year: _____
- Date(s) of previous CDI episode(s) within the last year: _____

☐ Current CDI episode is confirmed with a positive stool test for *C. difficile* toxin.

- Date stool sample collected: _____

☐ The patient will have completed a full course of antibiotic therapy for the most recent CDI episode 24 to 72 hours prior to Rebyota® administration.

Specify antibacterial therapy for current CDI:

Antibacterial therapy for CDI	Dose	Route	Frequency	Date Started	Anticipated Stop Date
☐ Fidaxomicin (Dificid®)					
☐ Vancomycin					
☐ Metronidazole					
☐					

☐ Current CDI episode is well controlled (i.e., reduced stool frequency).

LAB AND TEST RESULTS (required)

☐ Positive *C. difficile* stool test