

Contact Info:

| | |
|--------|------|
| | |
| Phone: | Fax: |

 Date: _____ Start of Care: _____ Auth #: _____ Auth Dates: _____ UPMC prior auth form attached

PATIENT INFORMATION

| | | | |
|--------------------|--------|---------------|------|
| Patient Name: | | Patient DOB: | |
| Phone: | Email: | | |
| Address: | City: | State: | Zip: |
| Emergency Contact: | Phone: | Relationship: | |

INSURANCE INFORMATION

| | | | |
|----------------------|-----------|----------|----------|
| Primary Insurance: | Policy #: | Group #: | Insured: |
| Secondary Insurance: | Policy #: | Group #: | Insured: |

CLINICAL INFORMATION & PRIMARY DIAGNOSIS (ICD 10)

| | | | |
|--|---------|---------------------------------|---|
| Height: | Weight: | Allergies: | Latex Allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diagnosis: | | <input type="checkbox"/> Other: | |
| <input type="checkbox"/> A04.71 - Enterocolitis due to Clostridium difficile, recurrent | | | |
| <input type="checkbox"/> A04.72 - Enterocolitis due to Clostridium difficile, not specified as recurrent | | | |

PRESCRIPTION INFORMATION

| MEDICATION | DIRECTIONS | QUANTITY | REFILLS |
|-----------------------------------|---|----------|---------|
| <input type="checkbox"/> Rebyota® | Date of last dose of oral antibiotic: _____ <input type="checkbox"/> 150ml administered rectally x1 dose <input type="checkbox"/> Epi-kit | 1 | 0 |
| <input type="checkbox"/> Vowst™ | Date of last dose of oral antibiotic: _____ 1 dose = 4 capsules <input type="checkbox"/> Take 4 capsules once daily by mouth on an empty stomach prior to the first meal of the day for 3 days <input type="checkbox"/> Welcome Kit: Journal and (1) 10 oz. magnesium citrate saline laxative oral solution <input type="checkbox"/> Patient using an alternative laxative option | 12 | 0 |

PRESCRIBER INFORMATION

| | | | |
|-----------------------|---|--------|------|
| Date Shipment Needed: | Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician/Clinic <input type="checkbox"/> Other: | | |
| Physician Name: | Office Contact: | Phone: | Fax: |
| Address: | City: | State: | Zip: |
| Physician Signature: | Date: | | |

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

Include signed and completed order (this sheet completed and signed by provider)
 Include patient demographic information and insurance information (please complete all sections above)
 Include patient's current medication list
 Supporting clinical notes to support diagnosis including any past tried and/or failed therapies
 Patient has had at least one recurrence of CDI after an initial episode and has completed at least one round of standard treatment (i.e., oral vancomycin, Dificid)
 -OR-
 Patient has had two or more episodes of CDI resulting in hospitalization in the last year
 Include results of positive stool test confirming the presence of C. difficile toxin or toxigenic C. difficile within 30 days prior to treatment
 Other medical necessity: _____