PARAGON HEALTHCARE

REBYOTA (FECAL MICROBIOTA) RECTAL SUSPENSION

P: 888.588.1072 | **F:** 737.292.8997

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 737.292.8997

Patient Name: _____ DOB: _____ Phone: _____

Patient Status: ☐ New to Therapy ☐ Non-naive **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: ☐ Enterocolitis due to *Clostridium difficile*, recurrent (ICD-10 Code: A04.71)

☐ Enterocolitis due to *Clostridium difficile*, not specified as recurrent (ICD-10 Code: A04.72)

☐ Other: _____ (ICD-10 Code: _____)

Patient Weight: _____ lbs. (required) Allergies: _____

THERAPY ORDER

Rebyota Orders for the treatment of *Clostridioides difficile* infection (CDI), prophylaxis:

☐ 150 mL suspension for rectal use x 1 dose to be administered by a healthcare provider

Start date of antibiotics for treatment of CDI: _____ Duration of antibiotics: _____

Expected Rebyota start of care date: _____

- Dispense EpiPen 0.3mg IM (2-pack) per protocol

If you would like Paragon to fill the antibiotic for CDI treatment prior to Rebyota, please indicate below:

☐ Vancomycin 125mg PO four times daily for ☐ 10 days ☐ 14 days

☐ Other: _____

Other orders: _____

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Paragon Healthcare, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

☐ Opt out of Paragon selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

☐ Home ☐ Physician Office

View our locations here:

PARAGONHEALTHCARE.COM

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

PARAGON HEALTHCARE

COMPREHENSIVE SUPPORT FOR REBYOTA THERAPY

PATIENT INFORMATION:

Patient Name: _____ DOB: _____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- ☐ Include signed and completed order (MD/prescriber to complete page 1)
- ☐ Include patient demographic information and insurance information
- ☐ 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, metronidazole, 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: _____

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (737) 292-8997 or call (888) 588-1072 for assistance

IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.