Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Rebyota (Fecal Microbiota, Live-jslm)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:
Patient Weight: _____ kg or _____ lb	Patient Height: _____ in

REFERRAL STATUS

☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location (optional)

☐ Richmond ☐ Prince George

DIAGNOSIS AND ICD-10 CODE

☐ Enterocolitis due to Clostirdium Difficile, recurrent A04.71
☐ Other Diagnosis: ICD10 _____

REQUIRED DOCUMENTATION (must include)

☐ Patient Demographics ☐ Clinical/Progress Notes
☐ Insurance Information ☐ Positive C. Diff Lab Test(s)
☐ Documentation of recurrent CDI diagnosis, including:
Number of previous episodes:_____ AND Dates of previous episodes:_____

List Tried & Failed Therapies, including duration of treatment
1) 3)
2) 4)

MEDICATION ORDERS

☐ **Rebyota** 150mL rectally via gravity x 1 dose, 24 to 72 hours after last dose of antibacterial drug therapy for CDI

☐ Patient is actively on an antibacterial drug therapy (select one) ☐ Vancomycin ☐Dificid ☐Other:_____
Date Started Therapy:_____ **Anticipated Stop Date:**_____

☐By checking this box, the ordering provider agrees to allow Infusion Solutions Clinical Staff to coordinate timing of last dose of antibacterial drug therapy with the administration of Rebyota.
If not checked, patient will be scheduled 24-72 hours from above listed anticipated stop date.

OPTIONAL PREMEDICATIONS and LAB ORDERS

☐ Acetaminophen 650mg PO prior to rectal suspension
☐ Diphenhydramine 25mg PO prior to rectal suspension
☐ Ondansetron 4mg PO prior to rectal suspension
☐ Other PreMed or Lab Order with frequency: _____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com
Fax completed form and ALL required documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.