BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

REBYOTA® (FECAL MICROBIOTA, LIVE-JSLM)
INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

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

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: _____, ICD-10 _____

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: _____

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 current antibacterial therapy:

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).

Current CDI episode is confirmed with a positive stool test for *C. difficile* toxin. ***(Attach copy of test result.)***

Date stool sample collected: _____

LAB AND TEST RESULTS (required)

Positive *C. difficile* stool test