Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy

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Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Weight: _____

IV Access: _____ Height:_____

Allergies: _____

REBYOTA (fecal microbiota, live -jslm) Order Form

Please fax this form, copies of insurance cards, demographics, and supporting clinical documentation to **(360) 933-1197** to facilitate an efficient referral. Thank you for choosing Infusion Solutions!

Diagnoses:

☐ Recurrent *C. difficile* infection ICD-10: A04. 71

☐ Other: _____ ICD-10: _____

Screening Criteria:

Is this in response to at least the 2nd recurrence of *C. diff* infection (3rd occurrence)? ☐ Yes ☐ No

Has the patient received appropriate antibiotics for a *C. diff* infection? ☐ Yes ☐ No

Examples of appropriate regimens:

- Fidaxomicin
  - 200 mg orally twice daily for 10 days, OR
  - 200 mg orally twice daily for 5 days, followed by once every other day for 20 days
- Vancomycin in a tapered and pulsed regimen
- Vancomycin 125 mg orally 4 times daily for 10 days

Estimated last day of antibiotic therapy: _____

- Rebyota is indicated 24-72 hours after antibiotic therapy completion.
- Please allow at least 5 days from time of referral whenever possible.

Medication Orders:

- REBYOTA (fecal microbiota, live -jslm)
  - ☐ 150 ml administered rectally 24-72 hours after the last dose of antibiotics.
  - ☐ Other dose/instructions: _____
- Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

- Monitor for infusion/hypersensitivity reactions during infusions.
- Other: _____

Labs Orders: (if indicated)_____

_____ _____

Prescriber Signature *Date*

_____

Please Print Name

KEY: ◆ Orders are initiated unless crossed out by provider. **❑ Check box to initiate order.**