REBYOTA Enrollment Form

Please complete all required fields, sign, and submit this form to one of our designated specialty pharmacies to initiate a benefit investigation.

1. PATIENT INFORMATION (required)

Patient Name (full):	DOB: / /	Gender: ◯ M ◯ F ◯ Other
Street Address:		Apt #:
City:	State:	Zip Code:
Mobile Phone: - -	Home Phone: - -	
Preferred Phone: ◯ Mobile ◯ Home	Best Time to Call: ◯ AM ◯ PM	Email:
Authorized Representative:		Email:

2. INSURANCE INFORMATION (required)

Include a copy of the front and back of all insurance cards OR complete information below.

Insurance	Primary Medical	Secondary Medical (e.g.: MediGap coverage)	Prescription
Name & Type			
Phone Number			
Policy ID #			
Group #			
Policy Holder Name			
Policy Holder DOB	/ /	/ /	/ /
Relationship to Patient			
			PCN #:
			BIN #:

3. HEALTHCARE PROVIDER INFORMATION (required by treating healthcare provider)

Name (full):	Prescriber NPI #:	
Specialty:	State License #:	
Practice Name:	Tax ID #:	
Facility Street Address:	Suite #:	Facility NPI #:
City:	State:	Zip Code:
Office Phone: - - Ext.:	Office Fax: - -	
Contact Name (full):	Contact Email:	

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Patient Name (full): _____ Date of Birth: ____ / ____ / ____

4. CLINICAL INFORMATION (required by treating healthcare provider)

Diagnosis code (ICD-10 Code):
◯ Other:
◯ **A04.71** (Enterocolitis due to Clostridium difficile, **recurrent**)
◯ **A04.72** (Enterocolitis due to Clostridium difficile, **not specified as recurrent**)

Antibiotic treatment (if known): Start date: / / Days of therapy:

Expected date for administering REBYOTA® to patient: / /

Treatment location (billing as): ◯ 11: Physician Office ◯ 19/22: Outpatient Center ◯ 24: Ambulatory Surgery Center ◯ 12: Home (REBYOTA@Home)

5. PRESCRIPTION (required for patients serviced by a Specialty Pharmacy)

Date: / /		REBYOTA: 150 mL suspension for rectal use	Directions for use: Administered rectally by a healthcare provider	Special instructions:
Qty.: 1 unit = 150 mL	Refills:			
List or attach current medications:			List any medication allergies: ◯ No known drug allergies	

I verify that the patient and healthcare provider information on this enrollment form was completed by me or at my direction and I have discussed with my patient and informed patient of the REBYOTA enrollment. The information contained herein is complete and accurate to the best of my knowledge. I understand that I must comply with my practicing state's specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Noncompliance with state-specific requirements may result in the dispensing pharmacy reaching out to me.

By signing below, I certify that: (1) I am prescribing REBYOTA (fecal microbiota, live-jslm) ("Product") for the patient identified in Section 1 above, this prescription is medically necessary for the patient and that it will be used as directed; I will be supervising the patient's treatment, and that the information I have provided above is complete and accurate to the best of my knowledge; (2) I have received the appropriate permission and consent from the patient to comply with applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and applicable state laws needed to release to Ferring and its designated agents and service providers the patient-related information on this form for the purposes of verifying the patient's insurance coverage for Product, confirming prior authorization requirements for the Product, if needed, providing information on appeals of denials of claims, coordinating delivery of Product, contacting the patient with educational materials about the patient's prescription medication or to evaluate the effectiveness of the Program; and providing my patient with other education and support available through the Program associated with the Product; and (3) I authorize the above prescription to be forwarded to the specialty pharmacy or home health agency affiliated with patient's insurance plan or chosen by the named patient or by my office on the named patient's behalf.

SIGN HERE

_____ **Prescriber signature (Dispense as written/Do not substitute)**

_____ **Prescriber signature (Substitute allowed)**

_____ / _____ / _____ **Date**

Please send this form, filled out in its entirety to one of our specialty pharmacies:

Optum Frontier Therapies	**Accredo**	**REBYOTA@Home Chartwell**
Phone: 855-768-9727	Phone: 866-759-1557	Phone: 412-804-8554
Fax: 866-991-9929	Fax: 888-454-8488	Fax: 412-920-1828

For questions or assistance, please contact the specialty pharmacy directly.

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