



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Rebyota - Non-PDL

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the patient greater than or equal to 18 years of age?

Yes

No

Q2. Does the patient have a diagnosis of recurrent Clostridioides difficile infection (rCDI) as defined by both of the following: a. Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for 2 consecutive days; b. Positive stool test confirming a Clostridioides difficile infection?

Yes

No

Q3. Did the patient experience one or more recurrences of CDI following an initial episode of CDI?

Yes

No

Q4. Did the patient complete at least 10 days of oral vancomycin or oral fidaxomicin for rCDI 24 to 72 hours prior to initiating Rebyota?

Yes

No

Q5. Is the previous episode of CDI under control [e.g., less than 3 unformed/loose (i.e., Bristol Stool Scale type 6-7) stools/day for 2 consecutive days]?



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Member Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Will Rebyota be administered within 24 to 72 hours of completing antibiotic treatment for current CDI?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Has the patient previously received Rebyota, Vowst, or prior fecal microbiota transplants?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Is the medication prescribed by or in consultation with a gastroenterologist or infectious disease specialist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Additional Information:	

Prescriber Signature

Date

v2026-06