Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Rebyota
(Fecal Microbiota Suspension)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Rebyota ICD10:
☐ Other (please specify):

Directions for use: Dose Quantity: Duration of therapy:

Is this a new start or continuation of therapy?
☐ new start of therapy ☐ continuation of therapy

(if continued therapy) Please provide clinical support for the continued use of the requested drug:

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ Prevention of recurrence of Clostridioides difficile infection (CDI)
☐ other (please specify):

Clinical Information:

Has there been a Clostridioides difficile infection (CDI) confirmed by positive stool test for the current episode? ☐ Yes ☐ No

Have there been at least 2 recurrent CDI episodes (greater than or equal to 3 total CDI episodes)? ☐ Yes ☐ No

Will the patient receive the requested medication 24-72 hours following completion of an antibiotic course for CDI treatment? ☐ Yes ☐ No

Is the requested medication being prescribed by, or in consultation with, an infectious disease or gastrointestinal specialist? ☐ Yes ☐ No

Additional Information: *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (samples, out of pocket, etc.).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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