HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Rebyota - Non-PDL

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

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 fidaxomicind 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:

☐ Yes ☐ No

Q6. Is the medication is prescribed by or in consultation with a gastroenterologist or infectious disease specialist?

☐ Yes ☐ No

Q7. Additional Information:

_____ _____

Prescriber Signature Date

v2025