South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-22941

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WEB: DSS Medicaid Prior Authorizations | **EMAIL :** DSSMedicaidpa@state.sd.us

REBYOTA PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code:	**HCPC Code:**	
Drug Name:	**Quantity:**	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
Note: *The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.*		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	

CRITERIA			
☐	**Medical records to support use of product are submitted**		
Initial Therapy (check one)		**Yes** ☐	**No** ☐
☐	Therapy is prescribed by or in consultation with a gastroenterologist or infectious disease specialist		
☐	Individual has had a confirmed diagnosis of clostridiodes difficile infection as demonstrated by a positive stool test		
☐	Individual has had ≥2 relapses (initial episode and 2 recurrences) of CDI		
☐	Therapy is being utilized for prevention of additional CDI infections (contraindicated until individual has completed an approved treatment regimen)		
☐	Therapy will be administered within 24 to 72 hours of completing antibiotic treatment for current clostridiodes difficile infection		
☐	Individual has not previously received Rebyota, Vowst or prior fecal microbiota transplants within the last 2 years		
☐	Individual has failed therapy with pulsed dose fidaxomicin and bezlotoxumab (Zinplava)		
☐	Individual is ≥18 years of age		
PHYSICIAN SIGNATURE – PROVIDER ONLY			
This form must be signed by a provider			
☐	I certify that the information given in this form is a true and accurate medical indication for the required product		
Name & Title (Printed):			**Specialty:**
Signature:			