

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS

Note: This form is intended for prescriber use only, if faxed, the fax must come from prescriber's office or hospital (may not be faxed by patient).



Cystic Fibrosis Prescription/Pharmacy Intake Form

Pharmacy: _____ Pharmacy Phone: _____
 Pharmacy Fax: _____
 Date Needed: _____ Ship To: Prescriber's Office Patient's Home Other: _____

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient name: _____ DOB: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	Prescriber's name: _____ Practice/facility: _____
Address: _____	Address: _____
City: _____ State: _____ Zip code: _____	City: _____ State: _____ Zip code: _____
Phone # (Daytime): _____ Phone # (Evening): _____	Phone: _____ Fax: _____
<input type="checkbox"/> NKDA <input type="checkbox"/> Known drug allergies: _____	State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____
Weight: _____ lb <input type="checkbox"/> kg Date: _____ Height: _____ in <input type="checkbox"/> cm Date: _____	In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the below therapy is medically necessary and that the clinical assessment information below is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.
Insurance provider (Please include copy of front and back of card): _____	_____
<input type="checkbox"/> Patient is eligible for Medicare	_____
ID #: _____ Policy/Group #: _____ Phone #: _____	_____
	Dispense as written _____ Substitution permitted _____ Date _____

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

Patient is new to therapy Patient is currently on therapy ICD-10 code/description: _____ FEV1: _____ Date: _____

Concurrent meds: _____ Nebulizer purchase date/vendor: _____

CFTR mutation type: _____ Patient is: Heterozygous Homozygous for mutation(s) Bronchitol Tolerance Test Passed: Yes No

To assist with facilitating the prior authorization, please attach the following documents where appropriate. Please indicate the document(s) attached:

Failed therapies Recent laboratory results Recent pathology report Recent office notes Copy of front and back of insurance card

MEDICATION

Inhalations

<input type="checkbox"/> Albuterol Quantity: _____ Refills: _____ <input type="checkbox"/> 0.083% (3mL vial) <input type="checkbox"/> 0.5% (2.5mg/0.5mL) <input type="checkbox"/> Ventolin <input type="checkbox"/> Proair Directions: _____ <input type="checkbox"/> Bethkis 300mg/4ml amp Quantity: _____ Refills: _____ Directions: 1 vial via neb BID <input type="checkbox"/> 28 days on/28 days off <input type="checkbox"/> continuous <input type="checkbox"/> Bronchitol 4-week treatment pack (560 capsules) Quantity: _____ Refills: _____ Directions: 400 mg (10 capsules) by oral inhalation via inhaler twice daily, in the morning and 2-3 hours before bedtime. Use a short-acting bronchodilator via oral inhalation 5-15 minutes prior to every dose of Bronchitol. <input type="checkbox"/> Budesonide Quantity: _____ Refills: _____ <input type="checkbox"/> 0.25mg/2ml <input type="checkbox"/> 0.5mg/2ml Directions: _____ <input type="checkbox"/> Cayston <input type="checkbox"/> Altera Handset Quantity: _____ Refills: _____ <input type="checkbox"/> 75mg <input type="checkbox"/> Other: _____ Directions: 1 vial via neb TID 28 days on/28 days off	<input type="checkbox"/> Colistimethate Quantity: _____ Refills: _____ <input type="checkbox"/> 75mg <input type="checkbox"/> 150mg <input type="checkbox"/> 10ml Sterile H2O for injection <input type="checkbox"/> Syringe & Needle 5ml 22Gx1 1/2" <input type="checkbox"/> Sodium chloride 0.9% Directions: _____ Reconstitution instructions: _____ <input type="checkbox"/> Once daily <input type="checkbox"/> Twice daily <input type="checkbox"/> 28 days on/28 days off <input type="checkbox"/> continuous <input type="checkbox"/> Hyper-Sal Quantity: _____ Refills: _____ <input type="checkbox"/> 3.5% (4ml) <input type="checkbox"/> 7% (4ml) inhalation solution Directions: 4ml BID <input type="checkbox"/> Kitabis Pak 300mg/5ml amp Quantity: _____ Refills: _____ Directions: 1 vial via neb BID <input type="checkbox"/> 28 days on/28 days off <input type="checkbox"/> continuous <input type="checkbox"/> Levalbuterol Quantity: _____ Refills: _____ <input type="checkbox"/> 0.31mg/3ml <input type="checkbox"/> 0.63mg/3ml <input type="checkbox"/> 1.25mg/3ml Directions: _____	<input type="checkbox"/> Mucormyst Quantity: _____ Refills: _____ <input type="checkbox"/> 10% <input type="checkbox"/> 20% <input type="checkbox"/> Bd syringes (3mL, 5mL) Directions: _____ <input type="checkbox"/> Pulmosal 7% Quantity: _____ Refills: _____ Directions: 4ml BID <input type="checkbox"/> Pulmozyme 2.5mg/2.5ml amp Quantity: _____ Refills: _____ Directions: <input type="checkbox"/> One vial daily <input type="checkbox"/> One vial twice daily <input type="checkbox"/> Tobramycin (TOBI) 300mg/5ml amp Quantity: _____ Refills: _____ Directions: 1 vial via neb BID <input type="checkbox"/> 28 days on/28 days off <input type="checkbox"/> continuous <input type="checkbox"/> TOBI Podhaler 28mg caps Quantity: _____ Refills: _____ Directions: 4 caps via podhaler BID <input type="checkbox"/> 28 days on/28 days off <input type="checkbox"/> continuous
--	---	--

CFTR Modulators

<input type="checkbox"/> Kalydeco (ivacaftor) Refills: _____ Ages 4 months to less than 6 months 25mg oral granules (5kg or greater) <input type="checkbox"/> 56 single-dose packets <input type="checkbox"/> 168 single-dose packets Directions: 1 packet po q 12h mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food	Ages 6 months to less than 6 years 25mg oral granules (5 kg to less than 7 kg) <input type="checkbox"/> 56 single-dose packets <input type="checkbox"/> 168 single-dose packets Directions: 1 packet po q 12h mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food	Ages 6 months to less than 6 years 50mg oral granules (7 kg to less than 14 kg) <input type="checkbox"/> 56 single-dose packets <input type="checkbox"/> 168 single-dose packets Directions: 1 packet po q 12h mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food	Ages 6 months to less than 6 years 75mg oral granules (14 kg or greater) <input type="checkbox"/> 56 single-dose packets <input type="checkbox"/> 168 single-dose packets Directions: 1 packet po q 12h mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food	Ages 6 years and older 150mg tablet <input type="checkbox"/> 56 tablets <input type="checkbox"/> 168 tablets Directions: 1 tablet po q 12h with fat-containing food
--	--	---	--	---

<input type="checkbox"/> Orkambi (lumacaftor/ivacaftor) Refills: _____ Ages 2 to less than 6 years 100/125mg oral granules (less than 14kg) <input type="checkbox"/> 56 single-dose packets <input type="checkbox"/> 168 single-dose packets Directions: 1 packet po q 12h mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food	Ages 2 to less than 6 years 150/188mg oral granules (14kg or greater) <input type="checkbox"/> 56 single-dose packets <input type="checkbox"/> 168 single-dose packets Directions: 1 packet po q 12h mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food	Ages 6 to less than 12 years 100mg/125mg tablets <input type="checkbox"/> 112 tablets for 28-day supply <input type="checkbox"/> 336 tablets for 84-day supply Directions: 2 tablets po q 12h with fat-containing food	Ages 12 years and older 200mg/125mg tablets <input type="checkbox"/> 112 tablets for 28-day supply <input type="checkbox"/> 336 tablets for 84-day supply Directions: 2 tablets po q 12h with fat-containing food
---	---	--	---

<input type="checkbox"/> Symdeko (tezacaftor/ivacaftor and ivacaftor) Refills: _____ Ages 6 to less than 12 years 50mg/75mg + 75mg (less than 30kg) <input type="checkbox"/> 56 tablets <input type="checkbox"/> 168 tablets Directions: 1 white tablet in the morning and 1 light blue tablet in the evening, 12 hours apart, with fat-containing food	Ages 6 to less than 12 years 100mg/150mg + 150mg (30kg or greater) <input type="checkbox"/> 56 tablets <input type="checkbox"/> 168 tablets Directions: 1 yellow tablet in the morning and 1 light blue tablet in the evening, 12 hours apart, with fat-containing food	Ages 12 years and older 100mg/150mg + 150mg <input type="checkbox"/> 56 tablets <input type="checkbox"/> 168 tablets Directions: 1 yellow tablet in the morning and 1 light blue tablet in the evening, 12 hours apart, with fat-containing food
---	---	--

<input type="checkbox"/> Trikafta (elixacaftor/tezacaftor/ivacaftor and ivacaftor) Refills: _____ Ages 6 to less than 12 years 50mg/25mg/37.5mg + 75mg (less than 30kg) <input type="checkbox"/> 84 tablets <input type="checkbox"/> 252 tablets Directions: 2 light orange tablets in the morning and 1 light blue tablet in the evening, 12 hours apart, with fat-containing food	Ages 6 to less than 12 years 100mg/50mg/75mg + 150mg (30kg or greater) <input type="checkbox"/> 84 tablets <input type="checkbox"/> 252 tablets Directions: 2 orange tablets in the morning and 1 light blue tablet in the evening, 12 hours apart, with fat-containing food	Ages 12 years and older 100mg/50mg/75mg + 150mg <input type="checkbox"/> 84 tablets <input type="checkbox"/> 252 tablets Directions: 2 orange tablets in the morning and 1 light blue tablet in the evening, 12 hours apart, with fat-containing food
---	--	---

Digestive Enzymes

RELIZORB (IMMOBILIZED LIPASE) Cartridge Refills: _____

1 cartridge/day (500 mL) Dispense 30 each/cartridge

2 cartridge/day (1000 mL) Dispense 60 each/cartridge

Directions: Use 1 cartridge in-line with enteral feeding tube set, change cartridge with every 500 mL of enteral formula (max of 2 cartridges used/day)

Pancreatic Enzymes (Select one, please call us if prescribing more than one)

<input type="checkbox"/> Creon <input type="checkbox"/> 3,000u <input type="checkbox"/> 6,000u <input type="checkbox"/> 12,000u <input type="checkbox"/> 24,000u <input type="checkbox"/> 36,000u	<input type="checkbox"/> Pancreaze <input type="checkbox"/> 4,200u <input type="checkbox"/> 10,500u <input type="checkbox"/> 16,800u <input type="checkbox"/> 21,000u	<input type="checkbox"/> Pertzye <input type="checkbox"/> 4,000u <input type="checkbox"/> 8,000u <input type="checkbox"/> 16,000u <input type="checkbox"/> 24,000u	<input type="checkbox"/> Viokace <input type="checkbox"/> 10,440u <input type="checkbox"/> 20,880u	<input type="checkbox"/> Zenpep <input type="checkbox"/> 3,000u <input type="checkbox"/> 5,000u <input type="checkbox"/> 10,000u <input type="checkbox"/> 15,000u	Directions: _____ # of caps per meals: _____ # of caps per snacks: _____ Daily max: _____ Advise # of consumed meals and snacks per day (i.e. 3 meals and 3 snacks per day) Quantity: _____ Refills: _____
---	---	--	--	---	---

DME

<input type="checkbox"/> Aerobika Quantity: _____ Refills: _____	<input type="checkbox"/> Aeroeclipse XL Quantity: _____ Refills: _____	<input type="checkbox"/> Altera Handset <input type="checkbox"/> Altera System Quantity: _____ Refills: _____	<input type="checkbox"/> eRapid Handset <input type="checkbox"/> eRapid System Quantity: _____ Refills: _____	<input type="checkbox"/> PARI LC plus (pro) Quantity: _____ Refills: _____	<input type="checkbox"/> Other: _____ Quantity: _____ Refills: _____	<input type="checkbox"/> Mask <input type="checkbox"/> Adult <input type="checkbox"/> Bubbles Fish Mask
---	---	--	--	---	---	--

*** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA *** The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.