Cystic Fibrosis Enrollment Form

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

CFRX-20-01

CLINICAL CONSIDERATIONS

Diagnosis:
☐ E84.0 Cystic fibrosis with pulmonary manifestations
☐ E84.19 Cystic Fibrosis with intestinal manifestations
☐ E84.8 Cystic fibrosis with other manifestations
☐ E84.9 Cystic fibrosis, unspecified
☐ Other:_____

Other conditions:
☐ Pancreatic insufficiency

Is Pseudomonas aeruginosa present in airway culture?:
☐ Yes ☐ No

☐ FEV 1 _____ Date: ___ /___ /___

Immunization History
☐ Influenza
Date: ____ /____ / ____

History of therapies tried/failed (please include dates):

Rx

Medication	Dose/Strength	Directions	Quantity	Refills
☐ **Bethkis®** (tobramycin inhalation solution)	☐ 300 mg/4 mL ampule	☐ Inhale 300 mg (contents of one ampule) orally every 12 hours via nebulizer for 28 days on, followed by 28 days off		
☐ **Pulmozyme®** (dornase alfa)	☐ 2.5 mg/2.5 mL ampule	☐ Inhale 2.5 mg (contents of one ampule) orally once daily via nebulizer		
☐ **TOBI®** (tobramycin inhalation solution)	☐ 300 mg/5 mL ampule	☐ Inhale 300 mg (contents of one ampule) orally every 12 hours via nebulizer for 28 days on, followed by 28 days off		
☐ **Hyper-SAL®** (sodium chloride solution)	☐ 7% (4 mL vials)	☐ Inhale contents of one vial orally ____ times per day via nebulizer		
PANCREATIC ENZYMES ☐ **Creon®** (pancrelipase)	☐ 3,000 lipase unit capsule ☐ 6,000 lipase unit capsule ☐ 12,000 lipase unit capsule ☐ 24,000 lipase unit capsule ☐ 36,000 lipase unit capsule	Take listed number of capsules below with meal/snack and swallow whole (or sprinkle capsule(s) on a small amount of acidic soft food and take immediately by mouth) with water, juice, or other liquid. Do not mix directly into infant formula or breast milk. Do not crush or chew capsule shell or contents. Breakfast: ____ capsules/tablets Lunch: ____ capsules/tablets Dinner: ____ capsules/tablets Snacks: ____ capsules/tablets		
☐ **Pancreaze®** (pancrelipase)	☐ 2,600 lipase unit capsule ☐ 4,200 lipase unit capsule ☐ 10,500 lipase unit capsule ☐ 16,800 lipase unit capsule ☐ 21,000 lipase unit capsule			
☐ **Pertzye®** (pancrelipase)	☐ 4,000 lipase unit capsule ☐ 8,000 lipase unit capsule ☐ 16,000 lipase unit capsule ☐ 24,000 lipase unit capsule			
☐ **Viokace®** (pancrelipase)	☐ 10,440 lipase unit tablet ☐ 20,880 lipase unit tablet			
☐ **Zenpep®** (pancrelipase)	☐ 3,000 lipase unit capsule ☐ 5,000 lipase unit capsule ☐ 10,000 lipase unit capsule ☐ 15,000 lipase unit capsule ☐ 20,000 lipase unit capsule ☐ 25,000 lipase unit capsule ☐ 40,000 lipase unit capsule			

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____
NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____