

CYSTIC FIBROSIS REFERRAL FORM

Updated July 2019

Patient Name _____ Today's Date _____ NEW Patient CURRENT Patient
 DOB _____ Height _____ Weight _____ Male Female Preferred Language _____
 Best Phone _____ Email _____
 Street Address _____ Apt# _____ City _____ State _____ Zip _____
 Ship to Patient at: Home Physician Office Work Address _____
 Allergies _____
 Current Medications including OTC's (please fax a complete list) _____

Please Fax Insurance Card(s) both sides

Insured's Name _____
 Relation to Patient _____
Primary Insurance _____
 ID# _____ Group # _____
Secondary Insurance _____
 ID# _____ Group # _____

Ordering Prescriber

Office Contact _____
 Street Address _____ Suite # _____
 City _____ State _____ Zip _____
 Tel _____ Fax _____
 Email _____
 License# _____
 NPI# _____

ICD-10 Code E84.9 Cystic Fibrosis
 Blood Glucose test (if >14 y/o) _____ Most Recent PFT% _____
 Other Conditions: Pancreatic Insufficiency CFRD Osteoporosis Liver Disease
 Depression Other _____
 Yes No Is *Pseudomonas aeruginosa* present in airway cultures?
 Concomitant Medications _____

PRESCRIPTION

COLISTIMETHATE
 COLISTIMETHATE KIT *included as needed*
 contains sterile water for injection, syringes, needles and sharps container
 SIG: _____ QTY: _____ Refill: _____

HYPER-SAL® 7% SIG: _____ QTY: _____ Refill: _____

KALYDECO 150mg SIG: Take 1 tab every 12 hours orally QTY: _____ Refill: _____

PULMOZYME® 2.5mg SIG: _____ QTY: _____ Refill: _____

TOBI® 300mg Pari LC Nebulizer tubing recommended
 1 tube per inhaled treatment QTY: _____
 Replace tubing every 6 months: Yes No
 SIG: _____ QTY: _____ Refill: _____

NEBULIZER

PARI LC PLUS® Use as directed with compressor.
 Replace tubing every 6 months (Manufacturer and CF Foundation recommendation)
 SIG: _____ QTY: _____ Refill: _____

PANCREATIC ENZYMES

CREON® Creon® 5 Creon® 10 Creon® 20
 ZENPEP® Zenpep® 5 Zenpep® 10 Zenpep® 15 Zenpep® 20
 PANCREAZE® Pancreaze® 4 Pancreaze® 10 Pancreaze® 16 Pancreaze® 20
 SIG: _____ QTY: _____ Refill: _____

ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.

My signature authorizes the Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.