**Please fax both pages of completed form to your drug therapy team at 888.302.1028.**

To reach your team, call toll-free 855.315.3408.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

# Cystic fibrosis—inhaled

accredo®

**Four simple steps to submit your referral.**

## 1 Patient Information

**Please provide copies of front and back of all medical and prescription insurance cards.**

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Sex at birth: ☐ Male ☐ Female Preferred pronouns _____ Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

## 2 Prescriber Information

**All fields must be completed to expedite prescription fulfillment.**

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact e-mail _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Deliver product to: ☐ Prescriber's office ☐ Patient's home

## 3 Clinical Information

**Primary ICD-10 code:** _____ Patient weight _____ Height _____ Date measured _____

CFR Mutation type(s): ☐ F508del ☐ G551D ☐ G1244E ☐ G1244E ☐ G178R ☐ G551S ☐ S1251N ☐ S1255P

☐ S549N ☐ S549R ☐ R117H ☐ Other _____

Patient is: ☐ Heterozygous ☐ Homozygous for above mutation(s) FEV 1 _____ Date _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Baseline eye exam date _____ Last hearing screen _____

Serum Creatinine _____ Date _____ Estimated GFR _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

## 4 Prescribing Information

| Medication | Dose | Directions | Quantity/Refills |
|---|---|---|---|
| **Mucolytics** | | | |
| ☐ Pulmozyme® (dornase alfa) ampule | 2.5mg/2.5mL | ☐ Inhale contents of one ampule once daily with nebulizer.<br>☐ Other | Dispense:<br>☐ 1-month supply<br>☐ 3-month supply<br>☐ Other _____<br>Refills _____ |
| **Inhaled Antibiotics** | | | |
| ☐ TOBI® (tobramycin inhalation solution) | 300mg/5mL | ☐ Inhale contents of one ampule with nebulizer every 12 hours for 28 days. Followed by 28 days off drug.<br>☐ Other | Dispense:<br>☐ 1-month supply (1 box of 56 ampules)<br>☐ 3-month supply (2 boxes of 56 ampules)<br>☐ Other _____<br>Refills _____ |
| ☐ Kitabis Pak® (tobramycin inhalation solution with PARI LC Nebulizer) | 300mg/5mL | | |
| ☐ Bethkis® (tobramycin inhalation solution) | 300mg/4mL | | |
| ☐ Bronchitol® (mannitol inhalation powder) | 40mg capsules for inhalation | ☐ Inhale contents of 10 capsules (400mg) twice a day, in the morning and evening, with the later dose taken 2–3 hours before bedtime.<br>☐ Other | Dispense:<br>☐ 4-week Treatment Pack (4 x 7-day treatment packs), 4 inhalers, 560 capsules<br>☐ Other _____<br>Refills _____ |
| ☐ Tobi Podhaler® (tobramycin inhalation powder) | 28mg capsules for inhalation | ☐ Inhale contents of 4 capsules (112mg) every 12 hours using Podhaler device for 28 days, followed by 28 days off drug.<br>☐ Other | Dispense:<br>☐ 1-month supply (1 box of 224 capsules)<br>☐ 3-month supply (2 boxes of 224 capsules)<br>☐ Other _____<br>Refills _____ |
| ☐ Cayston® (aztreonam inhalation solution)<br>☐ Altera Nebulizer System (Controller, Altera Handsets, Connection Cord, AC Power Supply, 4 AA Batteries) | 75mg vial with diluent | ☐ Reconstitute with supplied diluent and inhale contents of one vial three times a day for 28 days. Followed by 28 days off drug.<br>☐ Other | Dispense:<br>☐ 1-month supply (1 box of 84 vials)<br>☐ 3-month supply (2 boxes of 84 vials)<br>☐ Other _____<br>Refills _____ |
| **Cayston Supplies:** Altera handset only (each refill) | | ☐ No supplies (Supplies will be sent with shipment unless indicated.) | Send quantity sufficient for medication days supply |

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

**Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)**

**SIGN HERE** _____ **Date** _____ **Dispense as written** _____ **Date** _____ **Substitution allowed**

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.

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