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

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Prescription & Enrollment Form

# Cystic fibrosis—oral

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**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 Pronouns _____ Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email 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 email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

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

## 3 Clinical Information

**Primary ICD-10 code (REQUIRED):** _____

Weight _____kg/lbs Height _____cm/in Date recorded _____

CFR Mutation type(s): ☐ F508del ☐ G551D ☐ G1244E ☐ G1349D ☐ 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 | Strength/Formulation | Directions | Quantity/Refills |
|---|---|---|---|
| **Mutation Correctors** | | | |
| ☐ Kalydeco® (ivacaftor) tablets | *(ages 6 years and older)*<br>150mg tablet | ☐ Take 1 tablet by mouth every 12 hours with fat-containing food.<br>☐ Other _____<br>*(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)* | ☐ 1-month supply<br>☐ 3-month supply<br>☐ Other<br>_____<br>Refills _____ |
| ☐ Kalydeco® (ivacaftor) oral granules | *(ages 1 month–5 years)*<br>☐ 5.8mg packet (aged 1–2 months; > 3kg)<br>☐ 13.4mg packet (aged 2–4 months; > 3kg)<br>☐ 25mg packet (aged 4–6 months; > 5kg)<br>☐ 25mg packet (aged > 6 months–5 years; 5-7kg)<br>☐ 50mg packet (aged > 6 months–5 years; 7-14kg)<br>☐ 75mg packet (aged > 6 months–5 years; > 14kg)<br>Patient weight _____ | ☐ Mix 1 packet of granules in one teaspoon (5mL) of soft food or liquid and administer every 12 hours with fat-containing food.<br>☐ Other _____<br>*(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)* | |
| ☐ Orkambi® (lumacaftor/ivacaftor) tablet | *(ages 6–11 years)*<br>☐ 100mg/125mg tablet<br>*(12 years and older)*<br>☐ 200mg/125mg tablet | ☐ Take 2 tablets by mouth every 12 hours with fat-containing food.<br>☐ Other _____<br>*(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.* | |
| ☐ Orkambi® (lumacaftor/ivacaftor) oral granules | *(ages 1–5 years)*<br>☐ 75mg/94mg granules (weight 7–9kg)<br>☐ 100mg/125mg granules (weight 9–14kg)<br>☐ 150mg/188mg granules (weight >14kg)<br>Patient weight _____ | ☐ Mix 1 packet of granules in one teaspoon (5mL) of soft food or liquid and administer every 12 hours with fat-containing food.<br>☐ Other _____<br>*(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)* | |
| ☐ Symdeko® (tezacaftor/ivacaftor + ivacaftor) tablets | ☐ 50mg/75mg tablet + 75mg tablet<br>☐ 100mg/150mg tablet + 150mg tablet | ☐ Take 1 white tablet in the morning, and 1 blue tablet in the evening approximately 12 hours apart with fat-containing food.<br>☐ Take 1 yellow tablet by mouth in the morning, and 1 blue tablet in the evening approximately 12 hours apart with fat-containing food.<br>☐ Other _____<br>*(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)* | |
| ☐ Trikafta® (elexacaftor/tezacaftor/ivacaftor + ivacaftor) tablets | *(ages 6 years and older)*<br>☐ 50mg/25mg/37.5mg tablet + 75mg tablet<br>☐ 100mg/50mg/75mg tablet + 150mg tablet<br>Patient weight _____ | ☐ Take 2 orange tablets by mouth in the morning, and 1 blue tablet in the evening approximately 12 hours apart with fat-containing food.<br>☐ Other _____<br>*(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)* | |
| ☐ Trikafta® (elexacaftor/tezacaftor/ivacaftor+ ivacaftor) granules | *(ages 2–5 years)*<br>☐ 80mg/40mg/60mg +59.5mg oral granules (weight < 14kg)<br>☐ 100mg/50mg/75mg +75mg oral granules (weight > 14kg)<br>Patient weight _____ | ☐ Mix 1 blue packet in one teaspoon (5mL) of soft food or liquid and take in the morning. Mix 1 green packet in one teaspoon (5mL) of soft food or liquid and take in the evening. Take with fat-containing food approximately 12 hours apart.<br>☐ Mix 1 orange packet in one teaspoon (5mL) of soft food or liquid and take in the morning. Mix 1 pink packet in one teaspoon (5mL) of soft food or liquid and take in the evening. Take with fat-containing food approximately 12 hours apart.<br>☐ Other _____<br>*(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors: please see package insert.)* | |
| ☐ Other _____ | | | |

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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