Prescription & Enrollment Form

# Cystic fibrosis—inhaled

accredo®

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

## 1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient first name _____

Last name _____ Middle initial _____

Date of birth _____ ❑ Male ❑ Female Last 4 digits of SSN _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Parent/guardian (if applicable) _____

Home phone _____ Work phone _____ Cell phone _____

Evening phone _____ E-mail address _____

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

**Please attach copies of front and back of patient's insurance cards or complete information below.**

Insurance company _____ Phone _____

Insured's name _____

Insured's employer _____ Relationship to patient _____

Identification # _____ Policy/group # _____

Prescription card: ❑ Yes ❑ No If yes, carrier _____

Policy # _____ Group # _____

Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance or foundation support (please attach information)? ❑ Yes ❑ No

Note: If copay assistance is needed for one or more medications, please ensure the appropriate manufacturer forms have been completed and indicate Accredo on the forms. For what drugs is manufacturer program support in place or being requested? _____

## 2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber's first name _____ Last name _____

Prescriber's title _____

If NP or PA, under direction of Dr. _____

Office contact and title _____

Office contact e-mail _____

Office/clinic/institution name _____

Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI # _____ License # _____

Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic

Clinic location _____

## 3 CLINICAL INFORMATION

**Primary ICD-10 code:** _____

Patient weight _____ Height _____ Date measured _____

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 _____

## 4 PRESCRIBING INFORMATION

| Medication | Strength/Formulation | Directions | Quantity/Refills |
|---|---|---|---|
| **Mucolytics** | | | |
| ❑ Pulmozyme® (dornase alfa) ampule | 2.5 mg/2.5 mL | ❑ Inhale contents of one ampule once daily with nebulizer.<br>❑ Other _____ | Dispense: ❑ 1-month supply ❑ 3-month supply<br>❑ Other _____ Refills _____ |
| **Inhaled Antibiotics** | | | |
| ❑ TOBI® (tobramycin inhalation solution) | 300 mg/5 mL | ❑ 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 _____ Refills _____ |
| ❑ Kitabis Pak® (tobramycin inhalation solution with PARI LC Nebulizer) | 300 mg/5 mL | | |
| ❑ Bethkis® (tobramycin inhalation solution) | 300 mg/4 mL | | |
| ❑ Tobi Podhaler® (tobramycin inhalation powder) | 28 mg capsules for inhalation | ❑ Inhale contents of 4 capsules (112 mg) 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 _____ Refills _____ |
| ❑ Cayston® (aztreonam inhalation solution)<br>❑ Altera Nebulizer System (Controller, Altera Handsets, Connection Cord, AC Power Supply, 4 AA Batteries) | 75 mg 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 _____ 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.

By signing below, I certify that the above therapy is medically necessary.

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

PHYSICIAN SIGNATURE REQUIRED

Date _____ Substitution allowed _____ Date _____ Dispense as written _____

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.

**Please fax completed form to the Cystic Fibrosis team at 888.302.1028.**

To reach your team, call toll-free 855.315.3408.

**You can now track shipments for all your Accredo patients.**
**Go to https://prescribers.accredo.com and click "Help" to register.**