Prescription & Enrollment Form

Cystic fibrosis—oral

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
Mutation Correctors			
❑ Kalydeco® (ivacaftor) tablets	*(ages 6 years and older)* 150 mg tablet	❑ Take one tablet by mouth every 12 hours with fat-containing food.	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Kalydeco® (ivacaftor) oral granules	*(ages 6 months–5 years)* ❑ 25 mg packet (weight 5–7 kg) ❑ 50 mg packet (weight 7–14 kg) ❑ 75 mg packet (weight ≥14 kg) Patient weight _____	❑ Mix one packet of granules in one teaspoon of soft food or liquid and administer every 12 hours with fat-containing food.	
❑ Orkambi® (lumacaftor/ivacaftor) tablet	*(ages 6–11 years)* ❑ 100 mg/125 mg *(12 years and older)* ❑ 200 mg/125 mg	❑ Take two tablets by mouth every 12 hours with fat-containing food. ❑ Other _____ *(Dose adjustment required if patient on telrithromycin, clarithromycin, ketoconazole, itraconazole, posaconazole or voriconazole, when starting Orkambi. See package labeling.)*	
❑ Orkambi® (lumacaftor/ivacaftor) oral granules	*(ages 2–5 years)* ❑ 100 mg/125 mg granules (weight < 14 kg) ❑ 150 mg/188 mg granules (weight ≥14 kg) Patient weight _____	❑ Mix one packet of granules in one teaspoon of soft food or liquid and administer every 12 hours with fat-containing food.	
❑ Symdeko® (tezacaftor/ivacaftor + ivacaftor) tablets	*(ages 6–11 years)* ❑ 50 mg/75 mg tablet + 75 mg tablet *(12 years and older)* ❑ 100 mg/150 mg tablet + 150 mg tablet	❑ *6–11 years:* Take one white tablet in the morning, and one blue tablet in the evening approximately 12 hours apart with fat-containing food. ❑ *12 years and older:* Take one yellow tablet by mouth in the morning, and one blue tablet in the evening approximately 12 hours apart with fat-containing food. ❑ Other _____ *(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)*	
❑ Trikafta™ (elexacaftor/tezacaftor/ivacaftor + ivacaftor) tablets	*(12 years and older)* ❑ 100 mg/50 mg/75 mg + 150 mg	❑ Take two orange tablets by mouth in the morning, and one blue tablet in the evening approximately 12 hours apart with fat-containing food. ❑ Other _____ *(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)*	

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.