Cystic Fibrosis Enrollment Form

CVS specialty®

Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

Phone: 1-800-896-1464

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____
Address: _____City, State, ZIP Code: _____
Gender: ☐ Male ☐ Female
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
Relationship to minor: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
Phone: _____Fax_____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ E84.0 Cystic Fibrosis ☐ E84.8 CF w/ other manifestations ☐ E84.19 CF w/ intestinal manifestations
☐ Other Code: _____ Description _____
☐ Mutation (1) _____ ☐ Mutation (2) _____

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm

For Bronchitol: Patient has passed the Bronchitol Tolerance Test (BTT): ☐ Yes ☐ No

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Hyper-Sal	7%	☐ Other: _____	Quantity:_____ Refills:_____
☐ Pulmozyme	2.5 mg	☐ Inhale contents of 1 ampule (2.5mg) via nebulizer once daily. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Bronchitol	400 mg	☐ Inhale 400mg (contents of 10 capsules) twice daily using Bronchitol inhaler ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tobi	300 mg/5 mL	☐ Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Kitabis Pak with Pari LC Plus nebulizer	300 mg/5 mL	☐ Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tobramycin Pak with Pari LC Plus nebulizer	300 mg/5mL	☐ Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tobramycin nebulization	300 mg/5 mL	☐ Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Bethkis	300 mg/4 mL	☐ Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tobipodhaler	28 mg capsules	Inhale 112mg (4 capsules) twice daily via the Podhaler device for 28 days, then off 28 days. Please follow inhalation directions carefully.	Quantity:_____ Refills:_____

ANTI-INFECTIVE THERAPY 1:

Therapy Ordered:

☐ Vancomycin: _____ ☐ Ceftriaxone: _____ ☐ Cefepime: _____ ☐ Daptomycin: _____ ☐ Other: _____

Dose: _____ **Frequency:** _____ **Start Date:** _____ **Duration:** _____

Labs: ☐ BMP, CBC w/ differential every Monday. ☐ Trough level after 3rd dose and with routine Monday

☐ Other: _____ labs if Vancomycin or Aminoglycoside

Flushes: ☐ NS 5 mL SASH and prn ☐ Heparin 20 units ☐ Heparin 100 units SASH and prn

Nebulizers: _____

Pancreatic Enzymes:

☐ Creon	☐ 3,000 ☐ 6,000 ☐ 12,000 ☐ 24,000 ☐ 36,000	Take ___with meals __ with snacks. Max ____ per day	Quantity:__ Refills:___
☐ Pancreaze	☐ 4,200 ☐ 10,500 ☐ 16,800 ☐ 21,000	Take ___with meals __ with snacks. Max ____ per day	Quantity:__ Refills:___
☐ Pertzye	☐ 8,000 ☐ 16,000	Take ___with meals __ with snacks. Max ____ per day	Quantity:__ Refills:___
☐ Viokase	☐ 10,440 ☐ 20,880	Take ___with meals __ with snacks. Max ____ per day	Quantity:__ Refills:___
☐ Zenpep	☐ 3,000 ☐ 5,000 ☐ 10,000 ☐15,000 ☐ 20,000 ☐ 25,000 ☐ 40,000	Take ___with meals __ with snacks. Max ____ per day	Quantity:__ Refills:___

Other Routine CF Medications: _____

Nutrition Support: ☐ Registered Dietitian Consult ☐ Tube Feeding ☐ Oral Supplements ☐ Parenteral Nutrition

A representative from Coram® CVS Specialty Infusion Services will contact you to coordinate your nutrition referral

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature: _____Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature: _____Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.