CYSTIC FIBROSIS ENROLLMENT FORM

PATIENT INFORMATION

Last Name _____ First Name _____

Social Security No _____ Date of Birth _____

Sex M ☐ F ☐ Weight _____ Height _____ Allergies _____

Home Phone _____ Work/Mobile _____

Home Address _____

City _____ State _____ Zip _____

PRESCRIBER INFORMATION

Primary Medical Insurance _____ Medical Insurance Phone _____

Subscriber Name _____

Rx Card (PBM) _____ Group No _____

Prescription Card Bin # _____ PCN # _____

TREATMENT ARRANGMENTS

•Start Date: _____ Ship Meds ☐Home ☐Doctor's Office

Teaching by: ☐Home Health ☐Doctor's Office ☐Other: _____

INSURANCE INFORMATION *(Please fax demographics & Insurance information)*

DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-9 or ICD-10)

☐ 277.0 Cystic Fibrosis

☐ Other: _____

☐ ICD - 10 CODE & DESCRIPTION : _____

Weight : _____ kg/lbs Height : _____ In/cm Allergies : _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
		Specialty Medications		
☐ COLISTIMETHATE				
☐ Colistimethate Kit – This complimentary kit (contains sterile water for injection, syringes, needles, & sharps container) will be included as needed with dispensing				
☐ HYPER-SAL	7%			
☐ PULMOZYME	2.5MG			
☐ TOBI	300mg/5ml			
☐ BETHIKS	300mg/4ml			
***Pari LC nebulizer: tubing recommended one tube per inhaled treatment – Quantity :		Replace tubing every 6 months? ☐ Yes ☐ No		
☐ TOBIPODHALER	28mg capsules	Inhale 4 capsules twice daily for 28 days, then off 28 days. Please follow inhalation directions carefully.		
☐ KALYDECO	150mg	Take 1 tablet by mouth twice daily.		

☐ **Nebulizer** _____

☐ **Pancreatic Enzymes** _____

☐ **Other Routine CF Medications** _____

Physician Signature: X _____ ☐ **DAW (Dispense as Written)** **Date:** _____

Physician Name: _____ **Phone:** _____ **Fax:** _____ **Office Contact:** _____

Physician Address: _____ **NPI:** _____ **DEA:** _____

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