

Cystic Fibrosis Enrollment Form



Fax Referral To: 1-844-823-5480

Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-866-845-6790

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION (Complete or include demographic sheet)

Patient Name: _____ DOB: _____ Gender: Male Female
 Address: _____ City, State, ZIP Code: _____
 Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below)
Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
 Primary Phone: _____ Alternate Phone: _____
 Email: _____ Last Four of SSN: _____ Primary Language: _____
 Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Hyper-Sal	7%	<input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Pulmozyme	2.5 mg	<input type="checkbox"/> Inhale contents of 1 ampule (2.5mg) via nebulizer once daily. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Bronchitol	400 mg	<input type="checkbox"/> Inhale 400mg (contents of 10 capsules) twice daily using Bronchitol inhaler <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Cayston <input type="checkbox"/> Altera Nebulizer System (controller, altera handset, connection cord, ac power supply, AA batteries)	75mg vial	<input type="checkbox"/> Reconstitute with supplied diluent and inhale 75mg (1 vial) via Altera nebulizer three times daily for 28 days, then off 28 days <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____

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: _____
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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 CVSSpecialty 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.

Cystic Fibrosis Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Tobi	300 mg/5 mL	<input type="checkbox"/> Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Kitabis Pak with Pari LC Plus nebulizer	300 mg/5 mL	<input type="checkbox"/> Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Tobramycin Pak with Pari LC Plus nebulizer	300 mg/5mL	<input type="checkbox"/> Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Tobramycin nebulization	300 mg/5 mL	<input type="checkbox"/> Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> Bethkis	300 mg/4 mL	<input type="checkbox"/> Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. <input type="checkbox"/> Other: _____	Quantity: _____ Refills: _____
<input type="checkbox"/> 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:

<input type="checkbox"/> Creon	<input type="checkbox"/> 3,000 <input type="checkbox"/> 6,000 <input type="checkbox"/> 12,000 <input type="checkbox"/> 24,000 <input type="checkbox"/> 36,000	Take ___ with meals ___ with snacks. Max ___ per day	Quantity: ___ Refills: ___
<input type="checkbox"/> Pancreaze	<input type="checkbox"/> 4,200 <input type="checkbox"/> 10,500 <input type="checkbox"/> 16,800 <input type="checkbox"/> 21,000	Take ___ with meals ___ with snacks. Max ___ per day	Quantity: ___ Refills: ___
<input type="checkbox"/> Pertzye	<input type="checkbox"/> 8,000 <input type="checkbox"/> 16,000	Take ___ with meals ___ with snacks. Max ___ per day	Quantity: ___ Refills: ___
<input type="checkbox"/> Viokase	<input type="checkbox"/> 10,440 <input type="checkbox"/> 20,880	Take ___ with meals ___ with snacks. Max ___ per day	Quantity: ___ Refills: ___
<input type="checkbox"/> Zenpep	<input type="checkbox"/> 3,000 <input type="checkbox"/> 5,000 <input type="checkbox"/> 10,000 <input type="checkbox"/> 15,000 <input type="checkbox"/> 20,000 <input type="checkbox"/> 25,000 <input type="checkbox"/> 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 provided as needed for administration

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits

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