For assistance, contact your pharmacy representative: _____ Phone: _____ (For providers only)

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).

Walgreens | allianceRx Walgreens + PRIME

Cystic Fibrosis
Prescription/Pharmacy Intake Form

☐Central Pharmacy: _____

☐Retail/Community Pharmacy Fax: _____ Pharmacy Phone: _____

Date Needed: _____ Ship To: ☐Prescriber's Office ☐Patient's Home ☐Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ ☐Male ☐Female

Address: _____

City: _____ State: _____ Zip code: _____

Phone # (Daytime): _____ Phone # (Evening): _____

☐NKDA ☐Known drug allergies: _____

Weight: _____ ☐lb ☐kg Date: _____ Height: _____ ☐in ☐cm Date: _____

Insurance provider (Please include copy of front and back of card):

☐Patient is eligible for Medicare

ID #: _____ Policy/Group #: _____ Phone #: _____

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____

State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature. I certify that the below therapy is medically necessary and that the clinical assessment information below is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_____ Dispense as written | _____ Substitution permitted | _____ Date

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

☐Patient is new to therapy ☐Patient is currently on therapy ICD-10 code/description: _____

Concurrent meds: _____

CFTR mutation type: _____ Patient is: ☐Heterozygous ☐Homozygous for mutation(s)

FEV1: _____ Date: _____

Nebulizer purchase date/vendor: _____

To assist with facilitating the prior authorization, please attach the following documents where appropriate. Please indicate the documents(s) attached:

☐Failed therapies ☐Recent laboratory results ☐Recent pathology report ☐Recent office notes ☐Copy of front and back of insurance card

MEDICATION

Inhalations

☐Albuterol
- ☐0.083% (3mL vial)
- ☐0.5% (2.5mg/0.5mL)
- ☐Ventolin
- ☐Proair

Directions: _____

Quantity:____ Refills:____

☐Bethkis 300mg/4ml amp

Directions:
1 vial via neb BID
☐28 days on/28 days off ☐continuous

Quantity:____ Refills:____

☐Budesonide
- ☐0.25mg/2ml
- ☐0.5mg/2ml

Directions: _____

Quantity:____ Refills:____

☐Cayston ☐Altera Handset
- ☐75mg
- ☐Other:

Directions:
1 vial via neb TID
28 days on/28 days off

Quantity:____ Refills:____

☐Colistin
- ☐75mg
- ☐150mg
- ☐10ml Sterile H2O for injection
- ☐Syringe & Needle 5ml 22Gx1 ½"
- ☐Sodium chloride 0.9%

Directions:
Reconstitution instructions: _____
☐Once daily ☐Twice daily
☐28 days on/28 days off ☐continuous

Quantity:____ Refills:____

☐Hyper-Sal
- ☐3.5% (4ml)
- ☐7% (4ml) inhalation solution

Directions:
4ml BID

Quantity:____ Refills:____

☐Kitabis Pak 300mg/5ml amp

Directions:
1 vial via neb BID
☐28 days on/28 days off ☐continuous

Quantity:____ Refills:____

☐Levalbuterol
- ☐0.31mg/3ml
- ☐0.63mg/3ml
- ☐1.25mg/3ml

Directions: _____

Quantity:____ Refills:____

☐Mucomyst
- ☐10%
- ☐20%
- ☐Bd syringes (3mL, 5mL)

Directions: _____

Quantity:____ Refills:____

☐Pulmosal 7%

Directions:
4ml BID

Quantity:____ Refills:____

☐Pulmozyme 2.5mg/2.5ml amp

Directions:
One vial daily

Quantity:____ Refills:____

☐TOBI 300mg/5ml amp

Directions:
1 vial via neb BID
☐28 days on/28 days off ☐continuous

Quantity:____ Refills:____

☐TOBI Podhaler 28mg caps

Directions:
4 caps via podhaler BID
☐28 days on/28 days off ☐continuous

Quantity:____ Refills:____

Pancreatic Enzymes

☐Creon
- ☐3,000u
- ☐6,000u
- ☐12,000u
- ☐24,000u
- ☐36,000u

☐Pancreaze
- ☐2,600u
- ☐4,200u
- ☐10,500u
- ☐16,800u
- ☐21,000u

☐Pertzye
- ☐4,000u
- ☐8,000u
- ☐16,000u

☐Viokace
- ☐10,440u
- ☐20,880u

☐Zenpep
- ☐3,000u
- ☐5,000u
- ☐10,000u
- ☐15,000u
- ☐20,000u
- ☐25,000u
- ☐40,000u

Directions:
# of caps per meals:____ # of caps per snacks:____ Daily max:____
Advise # of consumed meals and snacks per day (i.e. 3 meals and 3 snacks per day)
_____

Quantity:____ Refills:____

Vitamins

☐Aquadeks
- ☐Liquid
- ☐Chew Tab

☐DEKAS Plus
- ☐Capsule
- ☐Chew Tab
- ☐Liquid

☐DEKAS Essential
- ☐Capsule
- ☐Liquid

☐MVW Complete
- ☐Chew Tab
- ☐Capsule
- ☐Liquid

☐MVW D3000
- ☐Chew Tab
- ☐Capsule

☐MVW D5000
- ☐Capsule

☐Vitamin D
- ☐1,000u
- ☐2,000u
- ☐5,000u
- ☐50,000u

Directions: _____

Quantity:____ Refills:____

Antibiotics/GI Meds

☐Azithromycin
Strength:____
Directions: _____
Quantity:____ Refills:____

☐Lansoprazole
Strength:____
Directions: _____
Quantity:____ Refills:____

☐Omeprazole
Strength:____
Directions: _____
Quantity:____ Refills:____

☐Pantoprazole
Strength:____
Directions: _____
Quantity:____ Refills:____

☐Ranitidine
Strength:____
Directions: _____
Quantity:____ Refills:____

☐Miralax
Strength:____
Directions: _____
Quantity:____ Refills:____

DME

☐Aerobika
Quantity:____ Refills:____

☐Aeroeclipse XL
Quantity:____ Refills:____

☐Altera Handset ☐Altera System
Quantity:____ Refills:____

☐eRapid Handset ☐eRapid System
Quantity:____ Refills:____

☐PARI LC plus (pro)
Quantity:____ Refills:____

☐Other: _____
Quantity:____ Refills:____

☐Mask
☐Adult ☐Bubbles Fish Mask

CFR Potentiator

☐Kalydeco
Refills:____

150mg tablet (age 6 and older)
☐56 tablets
☐168 tablets
Directions: 1 tablet po q 12h with fat-containing food

50mg oral granules (age 2 to less than 6)
☐56 single-dose packets
☐168 single-dose packets
Directions: 1 packet po q 12h mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food

75mg oral granules (age 2 to less than 6)
☐56 single-dose packets
☐168 single-dose packets
Directions: 1 packet po q 12h mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food

☐Orkambi
Refills:____

100mg/125mg tablets (Pediatric) (ages 6-11)
☐112 tablets for 28-day supply
☐336 tablets for 84-day supply
Directions: 2 tablets po q 12h with fat-containing food

200mg/125mg tablets (ages 12 and older)
☐112 tablets for 28-day supply
☐336 tablets for 84-day supply
Directions: 2 tablets po q 12h with fat-containing food

Other: _____

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.