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 prescriber's 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** Quantity:___ Refills:___
- ☐0.083% (3mL vial)
- ☐0.5% (2.5mg/0.5mL)
- ☐Ventolin
- ☐Proair

Directions: _____

☐**Bethkis** 300mg/4ml amp Quantity:___ Refills:___
Directions: 1 vial via neb BID
☐28 days on/28 days off ☐continuous

☐**Budesonide** Quantity:___ Refills:___
- ☐0.25mg/2ml
- ☐0.5mg/2ml

Directions: _____

☐**Cayston** ☐Altera Handset Quantity:___ Refills:___
- ☐75mg
- ☐Other:

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

☐**Colistimethate** Quantity:___ Refills:___
- ☐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

☐**Hyper-Sal** Quantity:___ Refills:___
- ☐3.5% (4ml)
- ☐7% (4ml) inhalation solution

Directions: 4ml BID

☐**Kitabis Pak** 300mg/5ml amp Quantity:___ Refills:___
Directions: 1 vial via neb BID
☐28 days on/28 days off ☐continuous

☐**Levalbuterol** Quantity:___ Refills:___
- ☐0.31mg/3ml
- ☐0.63mg/3ml
- ☐1.25mg/3ml

Directions:_____

☐**Mucomyst** Quantity:___ Refills:___
- ☐10%
- ☐20%
- ☐Bd syringes (3mL, 5mL)

Directions:_____

☐**Pulmosal** 7% Quantity:___ Refills:___
Directions: 4ml BID

☐**Pulmozyme** 2.5mg/2.5ml amp Quantity:___ Refills:___
Directions: ☐One vial daily ☐One vial twice daily

☐**Tobramycin** 300mg/5ml amp Quantity:___ Refills:___
Directions: 1 vial via neb BID
☐28 days on/28 days off ☐continuous

☐**TOBI Podhaler** 28mg caps Quantity:___ Refills:___
Directions: 4 caps via podhaler BID
☐28 days on/28 days off ☐continuous

CFTR Potentiator

☐**Kalydeco** (ivacaftor) Refills:_____
- 150mg tablet (age 6 years and older): ☐56 tablets ☐168 tablets. Directions: 1 tablet po q 12h with fat-containing food
- 50mg oral granules (12 months to less than 6 years) (7 kg to less than 14 kg): ☐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 (12 months to less than 6 years) (14 kg or greater): ☐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** (lumacaftor/ivacaftor) Refills:_____
- 100/125mg oral granules (age 2 to less than 6 years) (less than 14kg): ☐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
- 150/188mg oral granules (age 2 to less than 6 years) (14kg or greater): ☐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
- 100mg/125mg tablets (ages 6-11 years): ☐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 years and older): ☐112 tablets for 28-day supply ☐336 tablets for 84-day supply. Directions: 2 tablets po q 12h with fat-containing food

☐**Symdeko** (tezacaftor/ivacaftor/ and ivacaftor) Refills:_____
100mg/150mg + 150mg (ages 12 years and older)
☐56 tablets
☐168 tablets
Directions: 1 yellow tablet in the morning and 1 light blue tablet in the evening, 12 hours apart, with fat-containing food

Pancreatic Enzymes (Select one, please call us if prescribing more than one)

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

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

☐**Pertzye**
- ☐4,000u
- ☐8,000u
- ☐16,000u
- ☐24,000u

☐**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 (Select one, please call us if prescribing more than one)

☐**Aquadeks**
- ☐Liquid
- ☐Chew Tab

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

☐**DEKAS Essential**
- ☐Capsule
- ☐Liquid

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

☐**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