

1 PATIENT INFORMATION

Patient's Name _____
Date of Birth _____ Male Female Last 4 digits of SSN _____
Street Address _____ Apt# _____
City _____ State _____ Zip _____
Parent/Guardian (if applicable) _____
Home Phone _____ Work Phone _____
Cell Phone _____ Evening Phone _____
E-mail address _____
Insurance Company Name _____
Insurance Company Phone No. _____
Insured's Name _____
Insured's Employer _____
Relationship to Patient _____
Identification No. _____ Policy/Group No. _____
Prescription Card No Yes If Yes, Carrier _____
Policy No. _____ Group No. _____
Is patient eligible for Medicare? No Yes **Please attach front and back copy of patient's insurance cards, if available.**

2 PRESCRIBER INFORMATION

Prescriber's Name _____
Office Contact _____
Clinic / Hospital Affiliation _____
Street Address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____
NPI No. _____ License No. _____
DEA No. _____
Physician Medicaid UPIN No. _____
MD Specialty _____

To reach your team, call toll-free 1 888 608-9010.
**Please fax completed form to the Cystic Fibrosis team
1 888 302-1028.**

3 CLINICAL INFORMATION

Primary ICD-9 Code: _____

Rx:

Pulmozyme® (dornase alfa)

SIG: Dose: _____ mg for inhalation using recommended nebulizer

Frequency: _____

Dispense Quantity: _____ Refills: _____

NKDA

Known Drug Allergies: _____

Tobi® (tobramycin)

SIG: Dose: _____ mg for inhalation using recommended nebulizer

Frequency: _____

Dispense Quantity: _____ Refills: _____

NKDA

Known Drug Allergies: _____

Deliver product to: Office Patient's Home Clinic Clinic Location

If shipped to physician's office, physician accepts on behalf of patient for administration in office

By signing below, I certify that the above therapy is medically necessary.

Prescriber's Printed Name _____

Prescriber's Signature (sign below) _____ Date _____

Dispense as Written

Substitution Allowed

(Physician attests this is his/her legal signature. **NO STAMPS**)