accredo®
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Prescription & Enrollment Form

# Cystic fibrosis—inhaled

**Four simple steps to submit your referral.**

## 1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient first name _____
Last name _____ Middle initial _____
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 _____
Patient's primary language: ❑ English ❑ Other If other, please specify _____

**Please attach copies of front and back of patient s insurance cards or complete information below.**

Insurance company _____ Phone _____
Insured's name _____
Insured's employer _____ Relationship to patient _____
Identification # _____ Policy/group # _____
Prescription card: ❑ Yes ❑ No If yes, carrier _____
Policy # _____ Group # _____
Is patient eligible for Medicare? ❑ Yes ❑ No
Does patient have a secondary insurance or foundation support (please attach information)? ❑ Yes ❑ No
Note: If copay assistance is needed for one or more medications, please ensure the appropriate manufacturer forms have been completed and indicate Accredo on the forms. For what drugs is manufacturer program support in place or being requested? _____

## 2 PRESCRIBER INFORMATION

**All fields must be completed to expedite prescription fulfillment.**

Date _____ Time _____ Date medication needed _____
Prescriber's first name _____ Last name _____
Prescriber's title _____
If NP or PA, under direction of Dr. _____
Office contact and title _____
Office contact e-mail _____
Office/clinic/institution name _____
Clinic/hospital affiliation _____
Street address _____ Suite # _____
City _____ State _____ Zip _____
Phone _____ Fax _____
NPI # _____ License # _____
Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic
Clinic location _____

## 3 CLINICAL INFORMATION

**Primary ICD-10 code:** _____
Patient weight _____ Height _____ Date measured _____
CFR Mutation type(s): ❑ F508del ❑ G551D ❑ G1244E ❑ G1349D ❑ G178R ❑ G551S ❑ S1251N ❑ S1255P ❑ S549N ❑ S549R ❑ R117H ❑ Other _____
Patient is: ❑ Heterozygous ❑ Homozygous for above mutation(s)
FEV 1 _____ Date _____
❑ NKDA ❑ Known drug allergies _____
Concurrent meds _____
Baseline eye exam date _____ Last hearing screen _____
Serum Creatinine _____ Date _____ Estimated GFR _____

## 4 PRESCRIBING INFORMATION

| Medication | Strength/Formulation | Directions | Quantity/Refills |
|---|---|---|---|
| **Mucolytics** | | | |
| ❑ Pulmozyme® (dornase alfa) ampule | 2.5mg/2.5mL | ❑ Inhale contents of one ampule once daily with nebulizer.<br>❑ Other _____ | Dispense: ❑ 1-month supply ❑ 3-month supply<br>❑ Other _____ Refills _____ |
| **Inhaled Antibiotics** | | | |
| ❑ TOBI® (tobramycin inhalation solution) | 300mg/5mL | ❑ Inhale contents of one ampule with nebulizer every 12 hours for 28 days. Followed by 28 days off drug.<br>❑ Other _____ | Dispense:<br>❑ 1-month supply (1 box of 56 ampules)<br>❑ 3-month supply (2 boxes of 56 ampules)<br>❑ Other _____ Refills _____ |
| ❑ Kitabis Pak® (tobramycin inhalation solution with PARI LC Nebulizer) | 300mg/5mL | | |
| ❑ Bethkis® (tobramycin inhalation solution) | 300mg/4mL | | |
| ❑ Tobi Podhaler® (tobramycin inhalation powder) | 28mg capsules for inhalation | ❑ Inhale contents of 4 capsules (112mg) every 12 hours using Podhaler device for 28 days, followed by 28 days off drug.<br>❑ Other _____ | Dispense:<br>❑ 1-month supply (1 box of 224 capsules)<br>❑ 3-month supply (2 boxes of 224 capsules)<br>❑ Other _____ Refills _____ |
| ❑ Cayston® (aztreonam inhalation solution)<br>❑ Altera Nebulizer System (Controller, Altera Handsets, Connection Cord, AC Power Supply, 4 AA Batteries) | 75mg vial with diluent | ❑ Reconstitute with supplied diluent and inhale contents of one vial three times a day for 28 days. Followed by 28 days off drug.<br>❑ Other _____ | Dispense:<br>❑ 1-month supply (1 box of 84 vials)<br>❑ 3-month supply (2 boxes of 84 vials)<br>❑ Other _____ Refills _____ |
| **Cayston Supplies:** Altera handset only (each refill) ❑ No supplies (Supplies will be sent with shipment unless indicated.) | | | Send quantity sufficient for medication days supply |

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. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including thesubmission of any necessary forms to such health plans, to the extent not prohibited. **Prescriber's signature (sign below)** **(Physician attests this is his/her legal signature. NO STAMPS)**

_____ _____ _____ _____
Date Dispense as written Date Substitution allowed

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.

## PHYSICIAN SIGNATURE REQUIRED

**Please fax completed form to the Cystic Fibrosis team at 808.650.6487.**

To reach your team, call toll-free 808.650.6488.

**You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.**