Please fax all pages of completed form to your 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.

Prescription & Enrollment Form

Cystic fibrosis—oral

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

Provider will read the following statement: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Deliver product to: ☐ Prescriber's office ☐ Patient's home

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____

Weight _____kg/lbs Height _____cm/in Date recorded _____

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 _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Mutation Correctors			
☐ Alyftrek (vanzacaftor/ tezacaftor/ deutivacaftor)	*(ages 6-11 years & weight < 40kg)* ☐ 4mg/20mg/50mg tablet Patient weight _____	☐ Take 3 tablets by mouth once daily with fat-containing food. ☐ Other _____ *(i.e., dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert)*	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
	(ages 6-11 years & weight > 40kg) *(ages 12 and up any weight)* ☐ 10mg/50mg/125mg tablet Patient weight _____	☐ Take 2 tablets by mouth once daily with fat-containing food. ☐ Other _____ *(i.e., dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert)*	
☐ Kalydeco® (ivacaftor) tablets	*(ages 6 years and older)* 150mg tablet	☐ Take 1 tablet by mouth every 12 hours with fat-containing food. ☐ Other _____ *(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)*	
☐ Kalydeco® (ivacaftor) oral granules	*(ages 1 month-5 years)* ☐ 5.8mg packet (aged 1–2 months; > 3kg) ☐ 13.4mg packet (aged 2–4 months; > 3kg) ☐ 25mg packet (aged 4–6 months; > 5kg) ☐ 25mg packet (aged > 6 months–5 years; 5–7kg) ☐ 50mg packet (aged > 6 months–5 years; 7–14kg) ☐ 75mg packet (aged > 6 months–5 years; > 14kg) Patient weight _____	☐ Mix 1 packet of granules in one teaspoon (5mL) of soft food or liquid and administer every 12 hours with fat-containing food. ☐ Other _____ *(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)*	
☐ Trikafta® (elexacaftor/ tezacaftor/ ivacaftor + ivacaftor) tablets	*(ages 6 years and older)* ☐ 50mg/25mg/37.5mg tablet + 75mg tablet ☐ 100mg/50mg/75mg tablet + 150mg tablet Patient weight _____	☐ Take 2 orange tablets by mouth in the morning, and 1 blue tablet in the evening approximately 12 hours apart with fat-containing food. ☐ Other _____ *(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)*	
☐ Trikafta® (elexacaftor/ tezacaftor/ ivacaftor+ ivacaftor) granules	*(ages 2–5 years)* ☐ 80mg/40mg/60mg +59.5mg oral granules (weight < 14kg) ☐ 100mg/50mg/75mg +75mg oral granules (weight > 14kg) Patient weight _____	☐ Mix 1 blue packet in one teaspoon (5mL) of soft food or liquid and take in the morning. Mix 1 green packet in one teaspoon (5mL) of soft food or liquid and take in the evening. Take with fat-containing food approximately 12 hours apart. ☐ Mix 1 orange packet in one teaspoon (5mL) of soft food or liquid and take in the morning. Mix 1 pink packet in one teaspoon (5mL) of soft food or liquid and take in the evening. Take with fat-containing food approximately 12 hours apart. ☐ Other _____ *(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors: please see package insert.)*	
☐ Other _____			

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

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE _____ _____ _____ _____

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.

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Mutation Correctors			
☐ Orkambi® (lumacaftor/ivacaftor) tablet	*(ages 6–11 years)* ☐ 100mg/125mg tablet *(12 years and older)* ☐ 200mg/125mg tablet	☐ Take 2 tablets by mouth every 12 hours with fat-containing food. ☐ Other _____ *(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)*	☐ 1-month supply ☐ 3-month supply ☐ Other _____ Refills _____
☐ Orkambi® (lumacaftor/ivacaftor) oral granules	*(ages 1–5 years)* ☐ 75mg/94mg granules (weight 7–9kg) ☐ 100mg/125mg granules (weight 9–14kg) ☐ 150mg/188mg granules (weight >14kg) Patient weight _____	☐ Mix 1 packet of granules in one teaspoon (5mL) of soft food or liquid and administer every 12 hours with fat-containing food. ☐ Other _____ *(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)*	
☐ Symdeko® (tezacaftor/ivacaftor + ivacaftor) tablets	☐ 50mg/75mg tablet + 75mg tablet ☐ 100mg/150mg tablet + 150mg tablet	☐ Take 1 white tablet in the morning, and 1 blue tablet in the evening approximately 12 hours apart with fat-containing food. ☐ Take 1 yellow tablet by mouth in the morning, and 1 blue tablet in the evening approximately 12 hours apart with fat-containing food. ☐ Other _____ *(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)*	
☐ Other _____			

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

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ _____ _____ _____

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.

accredo®