

Please fax both pages of completed form to your drug therapy team at 888.302.1028.

To reach your team, call toll-free 844.315.3408.

You can now monitor shipments and chat online if you have questions. Go to [MyAccredoPatients.com](http://MyAccredoPatients.com) to log in or get started.

Prescription & Enrollment Form

# Cystic fibrosis—inhaled

accredo®

Four simple steps to submit your referral.

## 1 Patient Information



Please attach copies of front and back of the patient's medical and prescription insurance cards.

New patient  Current patient

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_

Male  Female  Last 4 digits of SSN \_\_\_\_\_ Date of birth \_\_\_\_\_

Street address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Parent/guardian (if applicable) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Alternate caregiver/contact \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

OK to leave message with alternate caregiver/contact

Patient's primary language: English  Other  If other, please specify \_\_\_\_\_

## 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 address \_\_\_\_\_

Office contact and title \_\_\_\_\_

Office contact phone number \_\_\_\_\_ Office contact e-mail \_\_\_\_\_

Office/clinic/institution name \_\_\_\_\_ Clinic/hospital affiliation \_\_\_\_\_

Street address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ NPI # \_\_\_\_\_ License # \_\_\_\_\_

## 3 Clinical Information

Primary ICD-10 code: \_\_\_\_\_ Patient weight \_\_\_\_\_ Height \_\_\_\_\_ Date measured \_\_\_\_\_

CFR Mutation type(s): F508del G551D G1244E G1244E 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	Dose	Directions	Quantity/Refills
<b>Mucolytics</b>			
Pulmozyme® (dornase alfa) ampule	2.5mg/2.5mL	Inhale contents of one ampule once daily with nebulizer. Other _____	Dispense: 1-month supply 3-month supply Other _____ Refills _____
<b>Inhaled Antibiotics</b>			
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. Other _____	Dispense: 1-month supply (1 box of 56 ampules) 3-month supply (2 boxes of 56 ampules) Other _____ Refills _____
Kitabis Pak® (tobramycin inhalation solution with PARI LC Nebulizer)	300mg/5mL		
Bethkis® (tobramycin inhalation solution)	300mg/4mL		
Bronchitol® (mannitol inhalation powder)	40mg capsules for inhalation	Inhale contents of 10 capsules (400mg) twice a day, in the morning and evening, with the later dose taken 2–3 hours before bedtime. Other _____	Dispense: 4-week Treatment Pack (4 x 7-day treatment packs), 4 inhalers, 560 capsules Other _____ Refills _____
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. Other _____	Dispense: 1-month supply (1 box of 224 capsules) 3-month supply (2 boxes of 224 capsules) Other _____ Refills _____
Cayston® (aztreonam inhalation solution) 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. Other _____	Dispense: 1-month supply (1 box of 84 vials) 3-month supply (2 boxes of 84 vials) Other _____ Refills _____
<b>Cayston Supplies:</b> 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.

**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.



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