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 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
Mucolytics			
☐ 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 _____
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. ☐ 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 _____
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.

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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