Please fax both 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 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 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 # _____

Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic Clinic location _____

3 Clinical Information

Primary ICD-10 code: _____ 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			
❑ Kalydeco® (ivacaftor) tablets	*(ages 6 years and older)* 150mg tablet	❑ Take one tablet by mouth every 12 hours with fat-containing food.	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
❑ Kalydeco® (ivacaftor) oral granules	*(ages 6 months–5 years)* ❑ 25mg packet (weight 5–7kg) ❑ 50mg packet (weight 7–14kg) ❑ 75mg packet (weight ≥ 14kg) Patient weight _____	❑ Mix one packet of granules in one teaspoon of soft food or liquid and administer every 12 hours with fat-containing food.	
❑ Orkambi® (lumacaftor/ivacaftor) tablet	*(ages 6–11 years)* ❑ 100mg/125mg *(12 years and older)* ❑ 200mg/125mg	❑ Take two tablets by mouth every 12 hours with fat-containing food. ❑ Other _____ *(Dose adjustment required if patient on telrithromycin, clarithromycin, ketoconazole, itraconazole, posaconazole or voriconazole, when starting Orkambi. See package labeling.)*	
❑ Orkambi® (lumacaftor/ivacaftor) oral granules	*(ages 2–5 years)* ❑ 100mg/125mg granules (weight < 14kg) ❑ 150mg/188mg granules (weight ≥ 14kg) Patient weight _____	❑ Mix one packet of granules in one teaspoon of soft food or liquid and administer every 12 hours with fat-containing food.	
❑ Symdeko® (tezacaftor/ivacaftor + ivacaftor) tablets	❑ 50mg/75mg tablet + 75mg tablet ❑ 100mg/150mg tablet + 150mg tablet	❑ Take one white tablet in the morning, and one blue tablet in the evening approximately 12 hours apart with fat-containing food. ❑ Take one yellow tablet by mouth in the morning, and one 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) tablets	❑ 50mg/25mg/37.5mg + 75mg ❑ 100mg/50mg/75mg + 150mg	❑ Take two orange tablets by mouth in the morning, and one 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.)*	

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 the submission 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) PHYSICIAN SIGNATURE REQUIRED

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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