

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**



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
<b>Mutation Correctors</b>			
<input type="checkbox"/> Kalydeco® (ivacaftor) tablets	(ages 6 years and older) 150mg tablet	<input type="checkbox"/> Take one tablet by mouth every 12 hours with fat-containing food.	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____  Refills _____
<input type="checkbox"/> Kalydeco® (ivacaftor) oral granules	(ages 6 months–5 years) <input type="checkbox"/> 25mg packet (weight 5–7kg) <input type="checkbox"/> 50mg packet (weight 7–14kg) <input type="checkbox"/> 75mg packet (weight ≥ 14kg) Patient weight _____	<input type="checkbox"/> Mix one packet of granules in one teaspoon of soft food or liquid and administer every 12 hours with fat-containing food.	
<input type="checkbox"/> Orkambi® (lumacaftor/ivacaftor) tablet	(ages 6–11 years) <input type="checkbox"/> 100mg/125mg (12 years and older) <input type="checkbox"/> 200mg/125mg	<input type="checkbox"/> Take two tablets by mouth every 12 hours with fat-containing food. <input type="checkbox"/> Other _____  (Dose adjustment required if patient on telrithromycin, clarithromycin, ketoconazole, itraconazole, posaconazole or voriconazole, when starting Orkambi. See package labeling.)	
<input type="checkbox"/> Orkambi® (lumacaftor/ivacaftor) oral granules	(ages 2–5 years) <input type="checkbox"/> 100mg/125mg granules (weight < 14kg) <input type="checkbox"/> 150mg/188mg granules (weight ≥ 14kg) Patient weight _____	<input type="checkbox"/> Mix one packet of granules in one teaspoon of soft food or liquid and administer every 12 hours with fat-containing food.	
<input type="checkbox"/> Symdeko® (tezacaftor/ivacaftor + ivacaftor) tablets	<input type="checkbox"/> 50mg/75mg tablet + 75mg tablet <input type="checkbox"/> 100mg/150mg tablet + 150mg tablet	<input type="checkbox"/> Take one white tablet in the morning, and one blue tablet in the evening approximately 12 hours apart with fat-containing food. <input type="checkbox"/> Take one yellow tablet by mouth in the morning, and one blue tablet in the evening approximately 12 hours apart with fat-containing food. <input type="checkbox"/> Other _____  (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)	
<input type="checkbox"/> Trikafta® (elexacaftor/tezacaftor/ ivacaftor) tablets	<input type="checkbox"/> 50mg/25mg/37.5mg + 75mg <input type="checkbox"/> 100mg/50mg/75mg + 150mg	<input type="checkbox"/> Take two orange tablets by mouth in the morning, and one blue tablet in the evening approximately 12 hours apart with fat-containing food. <input type="checkbox"/> 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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