



Phone: 844-265-1751  
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# Cystic Fibrosis Enrollment Form

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

## PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
Address 2 \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_  
DOB \_\_\_\_\_ Last Four of SS# \_\_\_\_\_ Gender \_\_\_\_\_  
Language Preference:  English  Spanish  Other \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber's Name \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Group/Hospital \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION *(Must fax a copy of patients insurance cards(s), including all secondary coverage)*

Prior Authorization Reference number \_\_\_\_\_

## MEDICAL INFORMATION *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

**Diagnosis** — Please include diagnosis name with ICD-10 code

E84.9 Cystic fibrosis, unspecified  
 E84.0 Cystic fibrosis with pulmonary manifestations  
 Other Diagnosis: ICD-10 Code \_\_\_\_\_  
Description \_\_\_\_\_  
Date of Diagnosis \_\_\_\_\_  
**Start Date** \_\_\_\_\_  
**Review Date** \_\_\_\_\_

**Additional Information**

Therapy:  New  Reauthorization  Restart

Weight \_\_\_\_\_ kg/lbs Height \_\_\_\_\_ cm/in  
Allergies \_\_\_\_\_  
Lab Data \_\_\_\_\_  
Prior Therapies \_\_\_\_\_  
Concomitant Medications \_\_\_\_\_  
Additional Comments \_\_\_\_\_

## PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions	Quantity	Refills
<input type="checkbox"/> Bethkis®				
<input type="checkbox"/> Kalydeco®				
<input type="checkbox"/> Kitabis® Pak				
<input type="checkbox"/> Orkambi™				
<input type="checkbox"/> Pulmozyme®				
<input type="checkbox"/> Symdeko™				
<input type="checkbox"/> TOBI®				
<input type="checkbox"/> TOBI® Podhaler				
<input type="checkbox"/> Trikafta™				

**\*Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Ship to:  Patient  Office  Other \_\_\_\_\_ Date \_\_\_\_\_ Needs by Date \_\_\_\_\_

Product Substitution permitted  Dispense as Written

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Supervising Physician Signature: \_\_\_\_\_ Date \_\_\_\_\_

Electronic or digital signatures not accepted.

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