

Phone: 844-265-1751 Fax: 844-232-7205

## **Cystic Fibrosis Enrollment Form**

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

This form is not a valid prescription in Arizona

PATIENT INFORMATION		PRESCRIBER II	PRESCRIBER INFORMATION			
Please complete the following or send patie	ent demographic sheet	Prescriber's Name				
Patient Name		DEA	DEA			
Address		NPI	NPI			
Address 2		Group/Hospital	Group/Hospital			
City, State, ZIP		Address	Address			
Home Phone Alternate Phone		City, State, ZIP	City, State, ZIP			
DOB Last Four of SS# Gender		Phone	Fax			
Language Preference: English Spanish Other		Contact Person	Phone	Phone		
INSURANCE INFORMATION	(Must fax a copy of patients insura	nce cards(s), including all seconda	ıry coverage)			
Prior Authorization Reference number		<u> </u>				
MEDICAL INFORMATION (Se	ection must be completed	d to process prescription	(Attach separate sheet	if needed)		
Diagnosis — Please include diagnosis nam	ne with ICD-10 code	Additional Information	Therapy: New F	Reauthorization [	Restart	
E84.9 Cystic fibrosis, unspecified		Weight	kg/lbs Height cm/in			
E84.0 Cystic fibrosis with pulmonary manifestations		Allergies				
Other Diagnosis: ICD-10 Code		Lab Data	Lab Data			
Description		Prior Therapies				
Date of Diagnosis		Concomitant Medication	ns			
Start Date						
		Additional Comments	Additional Comments			
Review Date		Additional Comments _				
		Additional Comments _				
PRESCRIPTION INFORMATION	ON	Additional Comments _				
	ON Dose/Strength	Directions		Quantity	Refills	
PRESCRIPTION INFORMATION					Refills	
PRESCRIPTION INFORMATION  Medication					Refills	
PRESCRIPTION INFORMATION  Medication  Kalydeco®					Refills	
PRESCRIPTION INFORMATION  Medication					Refills	
PRESCRIPTION INFORMATION  Medication  Kalydeco®  Orkambi™  Pulmozyme®					Refills	
PRESCRIPTION INFORMATION  Medication  Kalydeco®  Orkambi™  Pulmozyme®  Symdeko™					Refills	
PRESCRIPTION INFORMATION  Medication  Kalydeco®  Orkambi™  Pulmozyme®  Symdeko™  TOBI® Podhaler	Dose/Strength				Refills	
PRESCRIPTION INFORMATION  Medication  Kalydeco®  Orkambi™  Pulmozyme®  Symdeko™  TOBI® Podhaler  Tobramycin	Dose / Strength  300mg/5ml  representatives to act as my authorized agent to strengthing and the receipt and t	Directions  Directions	suthorization process for my patient(s), and atlent data. In the event that this pharmacy	Quantity  I to sign any necessary for y determines that it is une	orms on my	
PRESCRIPTION INFORMATION  Medication  Kalydeco®  Orkambi™  Pulmozyme®  Symdeko™  TOBI® Podhaler  Tobramycin  Trikafta™  *Prescriber Authorization: 1 authorize this pharmacy and its rebehalf as my authorized agent, including the receipt of any research.	Dose / Strength  300mg/5ml  representatives to act as my authorized agent to strengthing and the receipt and t	Directions  Directions  Secure coverage and initiate the insurance prior a and submission of patient lab values and other p d to coverage of the product to another pharmac	nuthorization process for my patient(s), and attent data. In the event that this pharmacy of the patient's choice or in the patient's	Quantity  I to sign any necessary for y determines that it is une	orms on my	
PRESCRIPTION INFORMATION  Medication  Kalydeco®  Orkambi™  Pulmozyme®  Symdeko™  TOBI® Podhaler  Tobramycin  Trikafta™  **Prescriber Authorization: I authorize this pharmacy and its rebehalf as my authorized agent, including the receipt of any rethis prescription, I further authorize this pharmacy to forward Ship to: Patient Office	Dose / Strength  300mg/5ml  approximation and any related materials related this information and any related materials related	Secure coverage and initiate the insurance prior a and submission of patient lab values and other p d to coverage of the product to another pharmac	nuthorization process for my patient(s), and attent data. In the event that this pharmacy of the patient's choice or in the patient's	Quantity  I to sign any necessary for y determines that it is una insurer's provider network	orms on my	
PRESCRIPTION INFORMATION  Medication  Kalydeco®  Orkambi™  Pulmozyme®  Symdeko™  TOBI® Podhaler  Tobramycin  Trikafta™  **Prescriber Authorization: I authorize this pharmacy and its rebehalf as my authorized agent, including the receipt of any rethis prescription, I further authorize this pharmacy to forward Ship to: Patient Office	Dose / Strength  300mg/5ml  representatives to act as my authorized agent to se required prior authorization forms and the receipt at this information and any related materials related  Other	secure coverage and initiate the insurance prior a and submission of patient lab values and other pd to coverage of the product to another pharmac	nuthorization process for my patient(s), and attent data. In the event that this pharmacy of the patient's choice or in the patient's	Quantity  I to sign any necessary for y determines that it is una insurer's provider network	orms on my	

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law if the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona.