For assistance, contact your pharmacy representative:_____ Phone:_____ **(For providers only)**

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS

Note: This form is intended for prescriber use only, if faxed, the fax must come from prescriber's office or hospital **(may not be faxed by patient).**

Walgreens | allianceRx Walgreens + PRIME

Cystic Fibrosis

Prescription/Pharmacy Intake Form

☐Central Pharmacy: _____

☐Retail/Community Pharmacy Fax: _____ Pharmacy Phone: _____

Date Needed: _____ **Ship To:** ☐Prescriber's Office ☐Patient's Home ☐Other: _____

PATIENT INFORMATION

Patient name: _____ DOB: _____ ☐Male ☐Female

Address: _____

City: _____ State: _____ Zip code: _____

Phone # (Daytime): _____ Phone # (Evening): _____

☐NKDA ☐Known drug allergies: _____

Weight: _____ ☐lb ☐kg Date: _____ Height: _____ ☐in ☐cm Date: _____

Insurance provider **(Please include copy of front and back of card)**:

☐Patient is eligible for Medicare

ID #: _____ Policy/Group #: _____ Phone #: _____

PRESCRIBER INFORMATION

Prescriber's name: _____ Practice/facility: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Fax: _____

State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature. I certify that the below therapy is medically necessary and that the clinical assessment information below is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_____ _____ _____

Dispense as written | Substitution permitted | Date

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription

☐Patient is new to therapy ☐Patient is currently on therapy ICD-10 code/description: _____

Concurrent meds: _____

CFTR mutation type: _____ Patient is: ☐Heterozygous ☐Homozygous for mutation(s)

FEV1: _____ Date: _____

Nebulizer purchase date/vendor: _____

To assist with facilitating the prior authorization, please attach the following documents where appropriate. Please indicate the documents(s) attached:

☐Failed therapies ☐Recent laboratory results ☐Recent pathology report ☐Recent office notes ☐Copy of front and back of insurance card

MEDICATION

Inhalations

☐**Albuterol** Quantity:___ Refills:___
- ☐0.083% (3mL vial)
- ☐0.5% (2.5mg/0.5mL)
- ☐Ventolin
- ☐Proair

Directions: _____

☐**Bethkis** 300mg/4ml amp Quantity:___ Refills:___
Directions: 1 vial via neb BID
☐28 days on/28 days off ☐continuous

☐**Budesonide** Quantity:___ Refills:___
- ☐0.25mg/2ml
- ☐0.5mg/2ml

Directions: _____

☐**Cayston** ☐Altera Handset Quantity:___ Refills:___
- ☐75mg
- ☐Other:

Directions: 1 vial via neb TID 28 days on/28 days off

☐**Colistimethate** Quantity:___ Refills:___
- ☐75mg
- ☐150mg
- ☐10ml Sterile H2O for injection
- ☐Syringe & Needle 5ml 22Gx1 ½"
- ☐Sodium chloride 0.9%

Directions:
Reconstitution instructions: _____
☐Once daily ☐Twice daily
☐28 days on/28 days off ☐continuous

☐**Hyper-Sal** Quantity:___ Refills:___
- ☐3.5% (4ml)
- ☐7% (4ml) inhalation solution

Directions: 4ml BID

☐**Kitabis Pak** 300mg/5ml amp Quantity:___ Refills:___
Directions: 1 vial via neb BID
☐28 days on/28 days off ☐continuous

☐**Levalbuterol** Quantity:___ Refills:___
- ☐0.31mg/3ml
- ☐0.63mg/3ml
- ☐1.25mg/3ml

Directions: _____

☐**Mucomyst** Quantity:___ Refills:___
- ☐10%
- ☐20%
- ☐Bd syringes (3mL, 5mL)

Directions: _____

☐**Pulmosal** 7% Quantity:___ Refills:___
Directions: 4ml BID

☐**Pulmozyme** 2.5mg/2.5ml amp Quantity:___ Refills:___
Directions: ☐One vial daily ☐One vial twice daily

☐**Tobramycin** 300mg/5ml amp Quantity:___ Refills:___
Directions: 1 vial via neb BID
☐28 days on/28 days off ☐continuous

☐**TOBI Podhaler** 28mg caps Quantity:___ Refills:___
Directions: 4 caps via podhaler BID
☐28 days on/28 days off ☐continuous

CFTR Modulators

☐**Kalydeco** (ivacaftor) Refills:_____

Ages 6 months to less than 6 years	Ages 6 months to less than 6 years	Ages 6 months to less than 6 years	Ages 6 years and older
25mg oral granules (5 kg to less than 7 kg)	50mg oral granules (7 kg to less than 14 kg)	75mg oral granules (14 kg or greater)	150mg tablet
☐56 single-dose packets	☐56 single-dose packets	☐56 single-dose packets	☐56 tablets
☐168 single-dose packets	☐168 single-dose packets	☐168 single-dose packets	☐168 tablets
Directions: 1 packet po q 12h mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food	Directions: 1 packet po q 12h mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food	Directions: 1 packet po q 12h mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food	Directions: 1 tablet po q 12h with fat-containing food

☐**Orkambi** (lumacaftor/ivacaftor) Refills:_____

Ages 2 to less than 6 years	Ages 2 to less than 6 years	Ages 6 to less than 12 years	Ages 12 years and older
100/125mg oral granules (less than 14kg)	150/188mg oral granules (14kg or greater)	100mg/125mg tablets	200mg/125mg tablets
☐56 single-dose packets	☐56 single-dose packets	☐112 tablets for 28-day supply	☐112 tablets for 28-day supply
☐168 single-dose packets	☐168 single-dose packets	☐336 tablets for 84-day supply	☐336 tablets for 84-day supply
Directions: 1 packet po q 12h mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food	Directions: 1 packet po q 12h mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food	Directions: 2 tablets po q 12h with fat-containing food	Directions: 2 tablets po q 12h with fat-containing food

☐**Symdeko** (tezacaftor/ivacaftor/ and ivacaftor) Refills:_____

Ages 6 to less than 12 years	Ages 6 to less than 12 years	Ages 12 years and older
50mg/75mg + 75mg (less than 30kg)	100mg/150mg + 150mg (30kg or greater)	100mg/150mg + 150mg
☐56 tablets	☐56 tablets	☐56 tablets
☐168 tablets	☐168 tablets	☐168 tablets
Directions: 1 white tablet in the morning and 1 light blue tablet in the evening, 12 hours apart, with fat-containing food	Directions: 1 yellow tablet in the morning and 1 light blue tablet in the evening, 12 hours apart, with fat-containing food	Directions: 1 yellow tablet in the morning and 1 light blue tablet in the evening, 12 hours apart, with fat-containing food

☐**Trikafta** (elexacaftor/tezacaftor/ivacaftor and ivacaftor) Refills:_____

Ages 12 years and older

100mg/50mg/75mg + 150mg

☐84 tablets

☐252 tables

Directions: 2 orange tablets in the morning and 1 light blue tablet in the evening, 12 hours apart, with fat-containing food

Digestive Enzymes

☐**RELiZORB (iMMOBILIZED LIPASE) Cartridge** Refills:_____

☐1 cartridge/day (500 mL) Dispense 30 each/cartridge

☐2 cartridge/day (1000 mL) Dispense 60 each/cartridge

Directions: Use 1 cartridge lin-line with enteral feeding tube set, change cartridge with every 500 mL of enteral formula (max of 2 cartridges used/day)

Pancreatic Enzymes (Select one, please call us if prescribing more than one)

☐**Creon**	☐**Pancreaze**	☐**Pertzye**	☐**Viokace**	☐**Zenpep**	
☐3,000u	☐4,200u	☐4,000u	☐10,440u	☐3,000u	☐20,000u
☐6,000u	☐10,500u	☐8,000u	☐20,880u	☐5,000u	☐25,000u
☐12,000u	☐16,800u	☐16,000u		☐10,000u	☐40,000u
☐24,000u	☐21,000u	☐24,000u		☐15,000u	
☐36,000u					

Directions:
# of caps per meals:_____ # of caps per snacks:_____ Daily max:_____
Advise # of consumed meals and snacks per day (i.e. 3 meals and 3 snacks per day)
Quantity:_____ Refills:_____

DME

☐Aerobika	☐Aeroeclipse XL	☐Altera Handset ☐Altera System	☐eRapid Handset ☐eRapid System	☐PARI LC plus (pro)	☐Other:_____	☐Mask
Quantity:_____ Refills:_____	Quantity:_____ Refills:_____	Quantity:_____ Refills:_____	Quantity:_____ Refills:_____	Quantity:_____ Refills:_____	Quantity:_____ Refills:_____	☐Adult ☐Bubbles Fish Mask

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.