Cystic Fibrosis Enrollment Form – Inhaled Therapies

CVS specialty®

Fax Referral To: 1-855-297-1270 **Phone:** 1-888-280-1190
Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982 **NCPDP:** 4026325

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____ City, State, ZIP Code: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____ **Relationship to patient**: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
Phone: _____ Fax _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

Is the Patient Insured? ☐ Yes ☐ No Is the Patient enrolled or eligible for Medicare/Medicaid? ☐ Yes ☐ No
Policy Holder's Name: _____ Policy Holder's DOB: _____ Relationship to Patient: _____
Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: _____
Prescription Insurance: _____ Prescription Plan Telephone: _____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #: _____ _____
☐ Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ E84.0 Cystic Fibrosis ☐ E84.8 CF w/ other manifestations ☐ E84.19 CF w/ intestinal manifestations
☐ Other Code: _____ Description _____
☐ Mutation (1) _____ ☐ Mutation (2) _____

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm

For Bronchitol: Patient has passed the Bronchitol Tolerance Test (BTT): ☐ Yes ☐ No

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Hyper-Sal	7%	☐ Other: _____	Quantity:_____ Refills:_____
☐ Pulmozyme	2.5 mg	☐ Inhale contents of 1 ampule (2.5mg) via nebulizer once daily. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Bronchitol	400 mg	☐ Inhale 400mg (contents of 10 capsules) twice daily using Bronchitol inhaler ☐ Other: _____	Quantity:_____ Refills:_____
☐ Cayston ☐ Altera Nebulizer System (controller, altera handset, connection cord, ac power supply, AA batteries)	75mg vial	☐ Reconstitute with supplied diluent and inhale 75mg (1 vial) via Altera nebulizer three times daily for 28 days, then off 28 days ☐ Other: _____	Quantity:_____ Refills:_____

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature:** _____ **Date:** _____	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature:** _____ **Date:** _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Cystic Fibrosis Enrollment Form – Inhaled Therapies

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____ Patient Phone: _____

Patient Address: _____

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Tobi	300 mg/5 mL	☐ Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Kitabis Pak with Pari LC Plus nebulizer	300 mg/5 mL	☐ Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tobramycin Pak with Pari LC Plus nebulizer	300 mg/5mL	☐ Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tobramycin nebulization	300 mg/5 mL	☐ Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Bethkis	300 mg/4 mL	☐ Inhale contents of 1 ampule (300mg) via nebulizer every 12 hours for 28 days, then off 28 days. ☐ Other: _____	Quantity:_____ Refills:_____
☐ Tobipodhaler	28 mg capsules	Inhale 112mg (4 capsules) twice daily via the Podhaler device for 28 days, then off 28 days. Please follow inhalation directions carefully.	Quantity:_____ Refills:_____

Ancillary supplies and kits provided as needed for administration

STAMP SIGNATURE NOT ALLOWED

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature: _____Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature: _____Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.