

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 IN	NFORMATION			
Please complete the following or send patie	ent demographic sheet	Prescriber's Name			_	
Patient Name		DEA	DEA			
Address		NPI			_	
Address 2		Group/Hospital			_	
City, State, ZIP		Address	Address			
Home Phone	Alternate Phone	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	ry coverage)			
Prior Authorization Reference number						
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	t	
E84.9 Cystic fibrosis, unspecified		Weight	kg/lbs Height	cm/	in	
E84.0 Cystic fibrosis with pulmonary man	nifestations	Allergies			_	
Other Diagnosis: ICD-10 Code		Lab Data				
Description		Prior Therapies			_	
Date of Diagnosis		Concomitant Medication	ns		_	
Start Date					_	
		Additional Comments	Additional Comments			
Review Date		Additional Commonto			_	
					_	
PRESCRIPTION INFORMATION	ON	, additional commonts				
	ON Dose/Strength	Directions		Quantity Refills		
PRESCRIPTION INFORMATION						
PRESCRIPTION INFORMATION  Medication						
PRESCRIPTION INFORMATION  Medication  Kalydeco®					-	
PRESCRIPTION INFORMATION  Medication						
PRESCRIPTION INFORMATION  Medication  Kalydeco®  Orkambi™  Pulmozyme®						
PRESCRIPTION INFORMATION  Medication  Kalydeco®  Orkambi™  Pulmozyme®  Symdeko™						
PRESCRIPTION INFORMATION  Medication  Kalydeco®  Orkambi™  Pulmozyme®  Symdeko™  TOBI® Podhaler	Dose/Strength					
PRESCRIPTION INFORMATION  Medication  Kalydeco®  Orkambi™  Pulmozyme®  Symdeko™  TOBI® Podhaler  Tobramycin	Dose / Strength  300mg/5ml  representatives to act as my authorized agent to strengthing programmer and the receipt and the re	Directions  Directions	uthorization process for my patient(s), and attent data. In the event that this pharmacy	Quantity Refills  It to sign any necessary forms on my y determines that it is unable to fulfill		
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 programmer and the receipt and the re	Directions  Directions	uthorization 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 Refills  It to sign any necessary forms on my y determines that it is unable to fulfill		
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 strequired prior authorization forms and the receipt at this information and any related materials related	Directions  Directions	uthorization 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 Refills  Ito sign any necessary forms on my y determines that it is unable to fulfill insurer's provider network.		
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 serequired prior authorization forms and the receipt at this information and any related materials related  Other	Directions  Directions  Directions	uthorization 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 Refills  Ito sign any necessary forms on my y determines that it is unable to fulfill insurer's provider network.		

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.