Cystic Fibrosis Enrollment Form – Oral Therapies

CVS specialty®

Fax Referral To: 1-877-232-5455
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727
NCPDP: 1203417

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)

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 _____
☐ CFTR Mutation (1) _____ ☐ CFTR Mutation (2) _____

Patient Clinical Information:

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

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Kalydeco (ivacaftor)	☐ 150 mg tablets	☐ Take 1 tablet by mouth every 12 hours with fat-containing food. ☐ Other _____ (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)	☐ 1-Month supply ☐ 3-Month supply ☐ Other Refills _____
	☐ 5.8 mg granules ☐ 13.4 mg granules ☐ 25 mg granules ☐ 50 mg granules ☐ 75 mg granules	☐ Mix 1 packet of granules in one teaspoon (5mL) of soft food or liquid and administer every 12 hours with fat-containing food. ☐ Other _____ (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)	
☐ Orkambi (lumacaftor/ ivacaftor)	☐ 100mg/125mg tablet ☐ 200mg/125mg tablet	☐ Take 2 tablets by mouth every 12 hours with fat-containing food. ☐ Other _____ (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)	☐ 1-Month supply ☐ 3-Month supply ☐ Other Refills _____
	☐ 75mg/94mg granules ☐ 100mg/125mg granules ☐ 150mg/188mg granules	☐ Mix 1 packet of granules in one teaspoon (5mL) of soft food or liquid and administer every 12 hours with fat-containing food. ☐ Other _____ (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)	

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.

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Please Complete Patient and Prescriber Information

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

Prescriber Name: _____ Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

☐ Symdeko (tezacaftor/ ivacaftor + ivacaftor)	☐ 50mg/75mg tablet + 75mg tablet	☐ Take 1 white tablet in the morning, and 1 blue tablet in the evening approximately 12 hours apart with fat-containing food. ☐ Other _____ (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)	☐ 1-Month supply ☐ 3-Month supply ☐ Other Refills _____
	☐ 100mg/150mg tablet + 150mg tablet	☐ Take 1 yellow tablet by mouth in the morning, and 1 blue tablet in the evening approximately 12 hours apart with fat-containing food. ☐ Other _____ (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)	
☐ Trikafta (elexacaftor/ tezacaftor/ ivacaftor + ivacaftor)	☐ 50mg/25mg/37.5mg tablet + 75mg tablet ☐ 100mg/50mg/75mg tablet + 150mg tablet	☐ Take 2 orange tablets by mouth in the morning, and 1 blue tablet in the evening approximately 12 hours apart with fat-containing food. ☐ Other _____ (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)	☐ 1-Month supply ☐ 3-Month supply ☐ Other Refills _____
	☐ 80mg/40mg/60mg + 59.5mg oral granules	☐ Mix 1 blue packet in one teaspoon (5mL) of soft food or liquid and take in the morning. Mix 1 green packet in one teaspoon (5mL) of soft food or liquid and take in the evening. Take with fat-containing food approximately 12 hours apart. ☐ Other _____ (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)	
	☐ 100mg/50mg/75mg + 75mg oral granules	☐ Mix 1 orange packet in one teaspoon (5mL) of soft food or liquid and take in the morning. Mix 1 pink packet in one teaspoon (5mL) of soft food or liquid and take in the evening. Take with fat-containing food approximately 12 hours apart. ☐ Other _____ (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)	

Pancreatic Enzymes:

☐ Creon	☐ 3,000 ☐ 6,000 ☐ 12,000 ☐ 24,000 ☐ 36,000	Take ___with meals ___ with snacks. Max ____ per day	Quantity:___ Refills:___
☐ Pancreaze	☐ 4,200 ☐ 10,500 ☐ 16,800 ☐ 21,000	Take ___with meals ___ with snacks. Max ____ per day	Quantity:___ Refills:___
☐ Pertzye	☐ 8,000 ☐ 16,000	Take ___with meals ___ with snacks. Max ____ per day	Quantity:___ Refills:___
☐ Viokase	☐ 10,440 ☐ 20,880	Take ___with meals ___ with snacks. Max ____ per day	Quantity:___ Refills:___
☐ Zenpep	☐ 3,000 ☐ 5,000 ☐ 10,000 ☐15,000 ☐ 20,000 ☐ 25,000 ☐ 40,000	Take ___with meals ___ with snacks. Max ____ per day	Quantity:___ Refills:___

Ancillary supplies and kits provided as needed for administration

STAMP SIGNATURE NOT ALLOWED

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