

Cystic Fibrosis Enrollment Form – Oral Therapies



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)

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

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

<input type="checkbox"/> Symdeko (tezacaftor/ ivacaftor + ivacaftor)	<input type="checkbox"/> 50mg/75mg tablet + 75mg tablet	<input type="checkbox"/> Take 1 white tablet in the morning, and 1 blue tablet in the evening approximately 12 hours apart with fat-containing food. <input type="checkbox"/> Other _____ <small>(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)</small>	<input type="checkbox"/> 1-Month supply <input type="checkbox"/> 3-Month supply <input type="checkbox"/> Other Refills _____
	<input type="checkbox"/> 100mg/150mg tablet + 150mg tablet	<input type="checkbox"/> Take 1 yellow tablet by mouth in the morning, and 1 blue tablet in the evening approximately 12 hours apart with fat-containing food. <input type="checkbox"/> Other _____ <small>(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)</small>	
<input type="checkbox"/> Trikafta (elexacaftor/ tezacaftor/ ivacaftor + ivacaftor)	<input type="checkbox"/> 50mg/25mg/37.5mg tablet + 75mg tablet <input type="checkbox"/> 100mg/50mg/75mg tablet + 150mg tablet	<input type="checkbox"/> Take 2 orange tablets by mouth in the morning, and 1 blue tablet in the evening approximately 12 hours apart with fat-containing food. <input type="checkbox"/> Other _____ <small>(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)</small>	<input type="checkbox"/> 1-Month supply <input type="checkbox"/> 3-Month supply <input type="checkbox"/> Other Refills _____
	<input type="checkbox"/> 80mg/40mg/60mg + 59.5mg oral granules	<input type="checkbox"/> 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. <input type="checkbox"/> Other _____ <small>(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)</small>	
	<input type="checkbox"/> 100mg/50mg/75mg + 75mg oral granules	<input type="checkbox"/> 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. <input type="checkbox"/> Other _____ <small>(i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)</small>	

Pancreatic Enzymes:

<input type="checkbox"/> Creon	<input type="checkbox"/> 3,000 <input type="checkbox"/> 6,000 <input type="checkbox"/> 12,000 <input type="checkbox"/> 24,000 <input type="checkbox"/> 36,000	Take ___ with meals ___ with snacks. Max ___ per day	Quantity:___ Refills:___
<input type="checkbox"/> Pancreaze	<input type="checkbox"/> 4,200 <input type="checkbox"/> 10,500 <input type="checkbox"/> 16,800 <input type="checkbox"/> 21,000	Take ___ with meals ___ with snacks. Max ___ per day	Quantity:___ Refills:___
<input type="checkbox"/> Pertzye	<input type="checkbox"/> 8,000 <input type="checkbox"/> 16,000	Take ___ with meals ___ with snacks. Max ___ per day	Quantity:___ Refills:___
<input type="checkbox"/> Viokase	<input type="checkbox"/> 10,440 <input type="checkbox"/> 20,880	Take ___ with meals ___ with snacks. Max ___ per day	Quantity:___ Refills:___
<input type="checkbox"/> Zenpep	<input type="checkbox"/> 3,000 <input type="checkbox"/> 5,000 <input type="checkbox"/> 10,000 <input type="checkbox"/> 15,000 <input type="checkbox"/> 20,000 <input type="checkbox"/> 25,000 <input type="checkbox"/> 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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