Cystic Fibrosis Enrollment Form – Oral Therapies

Fax Referral To: 1-844-823-5480
Email Referral To: Customer.ServiceFax@CVSHealth.com
Phone: 1-866-845-6790

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

Medication	Strength	Directions	Supply
☐ 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:

Enzyme	Strength	Directions	Quantity/Refills
☐ 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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