Foundation Care
An AcariaHealth Solution

Phone: 877.291.1122 • Fax: 877.291.1155

Date Shipment Needed: _____.

CYSTIC FIBROSIS REFERRAL FORM

PATIENT INFORMATION					
Patient Name:	DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.	
SSN:	Phone:	Allergies:			
Address:	City:	State:	Zip:		
Emergency Contact:	Phone:	❑ **Please attach demographic information**			

PRESCRIBER INFORMATION			
Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone: Fax:	Key Office Contact:	Phone:	

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: (ICD-10 Code & Description) _____

❑ E84.0CF w/ Pul Man. ❑J47.9 Bron w/o AC Exac

- Has patient been treated *previously* for this condition? ❑Yes ❑No Medication(s): _____
- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If yes: _____
- How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): _____

INSURANCE INFORMATION

❑ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑ **Please check if enrolling in copay card** | **Copay ID:**

PRESCRIPTION INFORMATION

Equipment: ❑eRapid™ Nebulizer ❑PARI LC PLUS® Nebulizer (QTY. 1, use as directed with nebulized medications, refill 11 or _____.)

Inhaled Medications	Dose	Treatment Regimen/Directions	QTY	Refills
❑**Bethkis**®	❑300 mg/4 mL	❑BID QOM ❑BID Monthly ❑Other: _____	1 month or _____	11 or _____
❑**Cayston** (aztreonam with Altera®)	❑75 mg	❑TID QOM ❑TID Monthly ❑Other: _____	1 month or _____	11 or _____
❑**Kitabis**	❑300 mg/5 mL	❑BID QOM ❑BID Monthly ❑Other: _____	1 month or _____	11 or _____
❑**Pulmozyme** ®(dornase alfa)	❑2.5 mg/2.5 mL (1 mg/1 mL)	❑Daily ❑BID ❑Other: _____	1 month or _____	11 or _____
❑**TOBI®** (tobramycin)	❑300 mg/5 mL	❑BID QOM ❑BID Monthly ❑Other: _____	1 month or _____	11 or _____
❑**Tobramycin**	❑300 mg/5 mL ❑300 mg/4 mL	❑BID QOM ❑BID Monthly ❑Other: _____	1 month or _____	11 or _____
❑**Tobi® Podhaler™**	❑4 (28 mg) capsules (2 inhalations/capsule)	❑BID QOM ❑BID Monthly ❑Other: _____	1 kit/month or ___	11 or _____
Oral Medications	**Dose**	**Treatment Regimen/Directions**	**QTY**	**Refills**
❑**Creon**®	❑3,000 USP ❑6,000 USP ❑12,000 USP ❑24,000 USP ❑36,000 USP	___With 3 meals and___with 4 snacks daily	1 month or _____	11 or _____
❑**Kalydeco**™(ivacaftor)	❑150 mg tabs	❑1 tablet Q12H ❑Other: _____	1 month or _____	11 or _____
❑**Kalydeco**	❑75 mg granules ❑50 mg granules ❑25 mg granules	❑1 packet Q12H ❑Other: _____	1 month or _____	11 or _____
❑**Orkambi**™ (lumacaftor/ivacaftor)	❑200 mg/125 mg tabs ❑100 mg/125 mg tabs	❑2 tablet Q12H ❑Other: _____	1 month or _____	11 or _____
❑**Orkambi**	❑100 mg/125 mg granules ❑150 mg/188 mg granules	❑1 packet Q12H ❑Other: _____	1 month or _____	11 or _____
❑**Pancreaze**®	❑2,600 USP ❑4,200 USP ❑10,500 USP ❑16,800 USP ❑21,000 USP ❑37,000 USP	___With 3 meals and___with 4 snacks daily	1 month or _____	11 or _____
❑**Pertzye**®	❑4,000 USP ❑8,000 USP ❑16,000 USP ❑24,000 USP	___With 3 meals and___with 4 snacks daily	1 month or _____	11 or _____
❑**Symdeko**™(tezacaftor/ivacaftor, invacaftor)	❑100 mg/150 mg and150 mg tabs	1 yellow tablet in am, 1 light blue tablet in pm, Q12H ❑Other: _____	1 month or _____	11 or _____
❑**Symdeko**	❑50 mg/75 mg and 75 mg tabs	1 white tablet in am, 1 light blue tablet in pm, Q12H ❑Other: _____	1 month or _____	11 or _____
❑**Trikafta**™ (elexacaftor/tezacaftor/ivacaftor, ivacaftor)	❑100 mg/50 mg/75 mg and 150 mg tabs	Take 2 orange tabs PO in am and 1 light blue tab in pm with fat-containing foods, Q12H	1 month or _____	11 or _____
❑**Trikafta**	❑50 mg/25 mg/ 37.5 mg and 75 mg tabs	Take 2 light orange tabs PO in am and 1 light blue tab in pm with fat-containing foods, Q12H ❑Other: _____	1 month or _____	11 or _____
❑**Viokace Oral**	❑10,440 USP ❑20,880 USP	___With 3 meals and___with 4 snacks daily ❑Other: _____	1 month or _____	11 or _____
❑**Zenpep**™	❑3,000 USP ❑5,000 USP ❑10,000 USP ❑15,000 USP ❑20,000 USP ❑25,000 USP ❑40,000 USP	___With 3 meals and ___with 4 snacks daily ❑Other: _____	1 month or _____	11 or _____

*Brand is Medically Necessary (Prescriber is required to handwrite): _____

Prescriber's Signature: _____ ❑ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through Foundation Care, this prescription shall be forwarded to an eligible pharmacy.