



SPECIALTY PHARMACY

WE HAVE A DEDICATED CF FAX LINE

CYSTIC FIBROSIS

Orlando, FL toll free 855.274.1694 toll free fax 844.306.0200

krogerspecialtypharmacy.com

PATIENT INFO		
Patient Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Address	City, State, Zip	
Phone	Allergies	
CFR Mutation	Weight <input type="checkbox"/> lbs <input type="checkbox"/> kg	

PRESCRIBER INFO		
Prescriber Name	Supervising MD NPI	
DEA#	NPI#	License #
Address	City, State, Zip	
Phone	Fax	

PLEASE FAX COPY OF: PRESCRIPTION CARD FRONT & BACK CLINICAL NOTES MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: E84.0 Cystic Fibrosis with pulmonary manifestations E84.9 Cystic Fibrosis unspecified E84.11 Meconium ileus in Cystic Fibrosis E84.19 Cystic Fibrosis with intestinal manifestations
 E84.8 Cystic Fibrosis with other manifestations B96.5 pseudomonas (mallei) causing diseases Other: _____

Drug Allergies: _____

MEDICATION	DOSE/STRENGTH	DIRECTIONS (FREQUENCY OF ADMINISTRATION)	QTY.	REFILLS
INHALATIONS:				
<input type="checkbox"/> Albuterol	<input type="checkbox"/> 0.083% (3mL vial) <input type="checkbox"/> 0.5% (2.5mg/0.5mL) <input type="checkbox"/> Ventolin <input type="checkbox"/> Proair	Directions:		
<input type="checkbox"/> Bethkis	300mg/4ml amp BID	select one: <input type="checkbox"/> 28 days on/28 days off <input type="checkbox"/> continuous		
<input type="checkbox"/> Budesonide	<input type="checkbox"/> 0.25mg/2ml <input type="checkbox"/> 0.5mg/2ml	Directions:		
<input type="checkbox"/> Cayston	75mg TID	Directions: 28 days on/28 days off		
<input type="checkbox"/> Colistin	<input type="checkbox"/> 75mg <input type="checkbox"/> 150mg <input type="checkbox"/> 5ml Sterile H2O for injection <input type="checkbox"/> Syringe & Needle 5ml 22Gx1 1/2" <input type="checkbox"/> Sodium chloride 0.9%	<input type="checkbox"/> once daily <input type="checkbox"/> twice daily select one: <input type="checkbox"/> 28 days on/28 days off <input type="checkbox"/> continuous		
<input type="checkbox"/> Hyper-Sal	<input type="checkbox"/> 3% (4ml) <input type="checkbox"/> 7% (4ml) inhalation solution	Directions:		
<input type="checkbox"/> Kitabis Pak	300mg/5ml amp 1 vial via neb BID	select one: <input type="checkbox"/> 28 days on/28 days off <input type="checkbox"/> continuous		
<input type="checkbox"/> Levalbuterol	<input type="checkbox"/> 0.31mg/3ml <input type="checkbox"/> 0.63mg/3ml <input type="checkbox"/> 1.25mg/3ml	Directions:		
<input type="checkbox"/> Mucomyst	<input type="checkbox"/> 10% <input type="checkbox"/> 20% inhalation solution <input type="checkbox"/> Bd syringes (3mL, 5mL)	Directions:		
<input type="checkbox"/> Pulmozyme	2.5mg/2.5ml amp	select one: <input type="checkbox"/> once daily <input type="checkbox"/> twice daily		
<input type="checkbox"/> TOBI	300mg/5ml amp BID 1 vial via neb BID	select one: <input type="checkbox"/> 28 days on/28 days off <input type="checkbox"/> continuous		
<input type="checkbox"/> TOBI Podhaler	28mg caps 4 caps via podhaler BID	select one: <input type="checkbox"/> 28 days on/28 days off <input type="checkbox"/> continuous		

PANCREATIC ENZYMES:				
<input type="checkbox"/> Creon	<input type="checkbox"/> 3,000 u <input type="checkbox"/> 6,000 u <input type="checkbox"/> 12,000 u <input type="checkbox"/> 24,000 u <input type="checkbox"/> 36,000 u	# of caps per meals: _____ # of caps per snacks: _____ Daily max: _____ Please advise # of consumed meals and snacks per day (i.e. 3 meals and 2 snacks per day): _____		
<input type="checkbox"/> Pancreaze	<input type="checkbox"/> 4,200 u <input type="checkbox"/> 10,500 u <input type="checkbox"/> 16,800 u <input type="checkbox"/> 21,000 u			
<input type="checkbox"/> Pertzeye	<input type="checkbox"/> 4,000 u <input type="checkbox"/> 8,000 u <input type="checkbox"/> 16,000 u <input type="checkbox"/> 24,000 u			
<input type="checkbox"/> Viokace	<input type="checkbox"/> 10,440 u <input type="checkbox"/> 20,880 u			
<input type="checkbox"/> Zenpep	<input type="checkbox"/> 3,000 u <input type="checkbox"/> 5,000 u <input type="checkbox"/> 10,000 u <input type="checkbox"/> 15,000 u <input type="checkbox"/> 20,000 u <input type="checkbox"/> 25,000 u <input type="checkbox"/> 40,000 u			

VITAMINS:				
<input type="checkbox"/> Aquadeks	<input type="checkbox"/> Chew Tab <input type="checkbox"/> Liquid	Directions:		
<input type="checkbox"/> Calcium carbonate	<input type="checkbox"/> 1250mg (500mg)	Directions:		
<input type="checkbox"/> DEKAS Essentials	<input type="checkbox"/> Capsule <input type="checkbox"/> Liquid	Directions:		
<input type="checkbox"/> DEKAS Plus	<input type="checkbox"/> Chew Tab <input type="checkbox"/> Liquid <input type="checkbox"/> Soft Gels	Directions:		
<input type="checkbox"/> MVW Complete	<input type="checkbox"/> Chew Tab <input type="checkbox"/> Drops <input type="checkbox"/> Soft Gels <input type="checkbox"/> D3000 <input type="checkbox"/> D5000	Directions:		
<input type="checkbox"/> Vitamin D	<input type="checkbox"/> 1,000 u <input type="checkbox"/> 2,000 u <input type="checkbox"/> 5,000 u <input type="checkbox"/> 50,000 u	Directions:		

ANTIBIOTICS/GI MEDS:		QTY.	REF.	DME:	QTY.	REF.	QTY.	REF.
<input type="checkbox"/> Azithromycin	Strength: Directions:			<input type="checkbox"/> Aerobika			<input type="checkbox"/> Other	
<input type="checkbox"/> Lansoprazole	Strength: Directions:			<input type="checkbox"/> Aeroclipse XL			<input type="checkbox"/> Other	
<input type="checkbox"/> Miralax	Strength: Directions:			<input type="checkbox"/> PARI LC plus (pro)			<input type="checkbox"/> Other	
<input type="checkbox"/> Omeprazole	Strength: Directions:			<input type="checkbox"/> PARI Trek S			<input type="checkbox"/> Other	
<input type="checkbox"/> Protonix	Strength: Directions:			<input type="checkbox"/> PARI Vios Pro			<input type="checkbox"/> Other	
<input type="checkbox"/> Zantac	Strength: Directions:			<input type="checkbox"/> PARI Vios Pro Filter			Please provide letter of medical necessity	

CFTR Potentiator: Please complete GPS enrollment form and fax to KSP with Rx							
<input type="checkbox"/> Kalydeco	150mg Tablet	po q 12h	50mg Oral Granules	po q 12h (1 to less than 6)	75mg Oral Granules	po q 12h (1 to less than 6)	
List mutations: _____	<input type="checkbox"/> 56 Tablets	(age 6 and older) with fat-containing food	<input type="checkbox"/> 56 Single-Dose Packets	mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food	<input type="checkbox"/> 56 Single-Dose Packets	mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food	
	<input type="checkbox"/> 168 Tablets		<input type="checkbox"/> 168 Single-Dose Packets		<input type="checkbox"/> 168 Single-Dose Packets		
<input type="checkbox"/> Orkambi (Pediatric)	F508del mutation <input type="checkbox"/> Yes <input type="checkbox"/> No	100-125mg Oral Granules	<input type="checkbox"/> 56 Single-Dose Packets	<input type="checkbox"/> 168 Single-Dose Packets	po q 12h (ages 2-5, weight less than 14kg) mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food		
<input type="checkbox"/> Orkambi (Pediatric)	F508del mutation <input type="checkbox"/> Yes <input type="checkbox"/> No	150-188mg Oral Granules	<input type="checkbox"/> 56 Single-Dose Packets	<input type="checkbox"/> 168 Single-Dose Packets	po q 12h (ages 2-5, weight greater than or equal to 14kg) mixed with 1 tsp (5mL) of soft food or liquid with fat-containing food		
<input type="checkbox"/> Orkambi (Pediatric)	F508del mutation <input type="checkbox"/> Yes <input type="checkbox"/> No	100mg/125mg Tablets 2 tablets po q 12h (ages 6-11) with fat-containing food	<input type="checkbox"/> 112 Tablets for 28-day supply	<input type="checkbox"/> 336 Tablets for 84-day supply			
<input type="checkbox"/> Orkambi	F508del mutation <input type="checkbox"/> Yes <input type="checkbox"/> No	200mg/125mg Tablets 2 tablets po q 12h (age 12 and older) with fat-containing food	<input type="checkbox"/> 112 Tablets for 28-day supply	<input type="checkbox"/> 336 Tablets for 84-day supply			
<input type="checkbox"/> Symdeko	F508del mutation <input type="checkbox"/> Yes <input type="checkbox"/> No	100-150mg/150 mg Tablets 1 tablet po q 12h (age 12 and older) with fat-containing food	<input type="checkbox"/> 56 Tablets for 28-day supply	<input type="checkbox"/> 168 Tablets for 84-day supply			
<input type="checkbox"/> Other							

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Substitution Permitted Date Prescriber's Signature (no stamps) Dispense As Written Date

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