Cystic Fibrosis
Prescription Referral Form

Phone: 1-877-592-7988
Fax: 1-800-787-0874

Rosemont Specialty Pharmacy
www.rosemontspecialtyrx.com

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Specialty Pharmacy
Expires 01/01/2020

6 Simple steps to submitting a referral

❶ PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ ☐Home ☐Cell ☐Work
Alternate Phone: _____ ☐Home ☐Cell ☐Work
DOB: _____ Gender: ☐Male ☐Female
E-mail: _____
Last Four of SS #: _____ Primary Language: _____

❷ PRESCRIPTION INFORMATION

Prescriber's Name: _____
State License #: _____ NPI # _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

❸ INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form if available (front and back)

❹ DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-9 or ICD-10)
☐ 277.0 Cystic Fibrosis
☐ Other: _____
☐ ICD-10 Code & Description: _____

☐ Mutation (1*) _____ ☐ Mutation (2*) _____
By signing below, physician confirms presence of the following indicated mutations:
G551D, G551S, S549R, G1244E, S1255P, G178R, S549N, S1251N, G1349D, R117H, F508del

Height: _____ in/cm Weight: _____ kg/lbs Allergies: _____

❺ PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
*☐ Colistimethate				
☐ Colistimethate Kit – This complimentary kit (*contains sterile water for injection, syringes, needles, & sharps container)* will be included as needed with dispensing.				
*☐ Hyper-Sal®	7%			
* ☐ Pulmozyme®	2.5mg			
* ☐ TOBI®	300mg/5ml			
☐ Kitabis Pak with Pari LC Plus nebulizer	300mg/5ml			
☐ Enroll Patient in PARI Provide Program to obtain DeVilbiss Pulmo-Aide Compressor ☐ DeVilbiss Pulmo-Aide Compressor (Q5 years)			 1	
* ☐ Tobramycin nebulization	300mg/5ml			
* ☐ Bethkis	300mg/4ml			
***Pari LC nebulizer: tubing recommended one tube per inhaled treatment – Quantity:_____ Replace tubing every 6 months? ☐ Yes ☐ No				
☐ TOBIPODHALER	28mg capsules	Inhale 4 capsules twice daily via the Podhaler device for 28 days, then off 28 days. Please follow inhalation directions carefully.		
☐ Kalydeco (lumacaftor)	☐ 150mg	Take 1 tablet PO Q12 hours with fat containing food	56 tablets 168 packets	
☐ Kalydeco Oral Granules	☐ 50mg granules ☐ 75mg granules	Mix granules with 1tsp (5mL of soft food or liquid) take PO Q12 hours with fat containing food	56 tablets 168 packets	
☐ Orkambi (lumacaftor/ivacaftor)	☐ 200mg/125mg ☐ 100mg/125mg (6-11 years)	Take 2 tablets (400mg/250mg) po Q12 hours with fat containing food (>11 years) Take 2 tablets (200mg/250mg) po Q12 hours with fat containing food (ages 6-11 years)	112 tablets	

Therapy Ordered:

Anti-Infective Therapy 1
☐ Vancomycin
☐ Ceftriaxone
☐ Cefepime
☐ Daptomycin
☐ Other:
Dose:_____
Frequency:_____
Start Date:_____
Duration:_____

Nebulizers

Pancreatic Enzymes

Other Routine CF Medications

Labs:
☐ BMP, CBC w/ differential q Monday.
☐ Trough level after 3rd dose and with routine Monday
☐Other: labs if Vancomycin or Aminoglycoside

Flushing:
☐ NS 5 ml SASH and prn
☐ Heparin 20 units
☐ Heparin 100 units SASH an dprn

Nutrition Support
☐ Registered Dietitian Consult
☐Oral Supplements
☐ Tube Feeding
☐ Parenteral Nutrition
A representative from Coram CVS/Specialty Infusion Services will contact you to coordinate your nutrition referral

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

PHYSICIAN SIGNATURE REQUIRED

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)

I authorize Rosemont Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.