

Patient Name First Name _____ Middle Name _____ Last Name _____ DOB _____ Weight _____ Male Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Daytime Tel _____ Evening Tel _____ Cell _____ Email _____

Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Pharmacy Date Needed _____ICD-10 Code E84.9 Cystic Fibrosis Blood Glucose test (if >14 y/o) _____ Most Recent PFT% _____ Allergies _____Other Conditions: Pancreatic Insufficiency CFRD Osteoporosis Liver Disease Depression Other _____Is *Pseudomonas aeruginosa* present in airway cultures? Yes No Concomitant Medications _____Insured's Name _____ Relation to Patient _____ Eligible for Medicare Yes No If yes, Medicare# _____Prescription Card Yes No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____

Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

 COLISTIMETHATE **COLISTIMETHATE KIT** *included as needed*
contains sterile water for injection,
syringes, needles and sharps container **HYPER-SAL**® 7% **KALYDECO** 150mg
SIG: Take 1 tab every 12 hours orally **PULMOZYME**® 2.5mg **TOBI**® 300mg *Pari LC Nebulizer tubing recommended*
1 tube per inhaled treatment Quantity: _____
Replace tubing every 6 months: Yes No

SIG _____

Quantity _____ Refill _____

NEBULIZER

 PARI LC PLUS® Use as directed with compressor.
Replace tubing every 6 months (Manufacturer and CF Foundation recommendation)
SIG _____ Quantity _____ Refill _____

PANCREATIC ENZYMES

CREON

 Creon®5 Creon®10 Creon® 20

ZENPEP

 Zenpep® 5 Zenpep® 10 Zenpep® 15 Zenpep® 20

PANCREAZE

 Pancreaze® 4 Pancreaze® 10 Pancreaze® 16 Pancreaze® 20

SIG _____ Quantity _____ Refill _____

 ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

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