Foundation Care™
An AcariaHealth Solution

Phone: 877.291.1122 • Fax: 877.291.1155

Date Shipment Needed: _____ Ship To: ☐ Patient ☐ Prescriber

# CYSTIC FIBROSIS REFERRAL FORM

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Patient Name: | | DOB: | Sex: ☐ M ☐ F ☐ Other: | Weight: | ☐ lbs. ☐ kg. |
| SSN: | Phone: | Allergies: | | | |
| Address: | | City: | State: | Zip: | |
| Emergency Contact: | | Phone: | ☐ **Additional Information Attached** | | |

## PRESCRIBER INFORMATION

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

## DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

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

☐ E84.0CF w/ Pul Man. ☐ J47.9 Bron w/o AC Exac ☐ B96.5 Pseudomonas aeruginosa

- 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 Plan Name:** | | |
| **Copay ID:** | **BIN #:** | **PCN #:** | **Group #:** | |

## 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®** *(tobramycin)* | ☐ 300 mg / 4 mL | ☐ Q12H QOM ☐ Q12H Monthly ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| ☐ **Cayston®** *(aztreonam with Altera®)* | ☐ 75 mg | ☐ TID QOM ☐ TID Monthly ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| ☐ **Kitabis®** *(tobramycin)* | ☐ 300 mg / 5 mL | ☐ Q12H QOM ☐ Q12H 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 | ☐ Q12H QOM ☐ Q12H Monthly ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| ☐ **Tobramycin®** | ☐ 300 mg / 4 mL ☐ 300 mg / 5 mL | ☐ Q12H QOM ☐ Q12H Monthly ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| ☐ **Tobi® Podhaler®** | ☐ 4 (28 mg) capsules (2 inhalations / capsule) | ☐ Q12H QOM ☐ Q12H Monthly ☐ 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.**

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# CYSTIC FIBROSIS REFERRAL FORM

## PATIENT INFORMATION

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|---|---|---|---|---|---|
| Patient Name: | | DOB: | Sex: ☐ M ☐ F ☐ Other: | Weight: | ☐ lbs. ☐ kg. |
| SSN: | Phone: | Allergies: | | | |
| Address: | | City: | State: | Zip: | |
| Emergency Contact: | | Phone: | ☐ **Additional Information Attached** | | |

## PRESCRIBER INFORMATION

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

## DIAGNOSIS INFORMATION / MEDICAL ASSESSMENT

***Primary Diagnosis:*** (ICD-10 Code & Description): _____ ☐ E84.0CF w/ Pul Man.

- 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 Plan Name:**

**Copy ID:** **BIN #:** **PCN #:** **Group #:**

## PRESCRIPTION INFORMATION

| ORAL MEDICATIONS | | DOSE | TREATMENT REGIMEN / DIRECTIONS | QTY | REFILLS |
|---|---|---|---|---|---|
| ☐ **Alyftrek®** *(vanzacaftor / tezacaftor / deutivacaftor)* | TABLETS | ☐ 4 mg / 20 mg / 50 mg | ☐ 3 Tabs daily w/ fat-containing foods ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| | | ☐ 10 mg / 50 mg / 125 mg | ☐ 2 Tabs daily w/ fat-containing foods ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| ☐ **Kalydeco®** *(ivacaftor)* | TABLETS | ☐ 150 mg | ☐ 1 Tab Q12H w/ fat-containing foods ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| | GRANULES | ☐ 5.8 mg ☐ 13.4 mg ☐ 25 mg ☐ 50 mg ☐ 75 mg | ☐ 1 Pack Q12H w/ fat-containing foods ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| ☐ **Orkambi®** *(lumacaftor / ivacaftor)* | TABLETS | ☐ 100 mg / 125 mg ☐ 200 mg / 125 mg | ☐ 2 Tabs Q12H w/ fat-containing foods ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| | GRANULES | ☐ 75 mg / 94 mg ☐ 100 mg / 125 mg ☐ 150 mg / 188 mg | ☐ 1 Pack Q12H w/ fat-containing foods ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| ☐ **Symdeko®** *(tezacaftor / ivacaftor, and ivacaftor)* | TABLETS | ☐ 100 mg / 150 mg and 150 mg | ☐ 1 yellow Tab in am, 1 light blue Tab in pm, Q12H w/ fat-containing foods ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| | | ☐ 50 mg / 75 mg and 75 mg | ☐ 1 white Tab in am, 1 light blue Tab in pm, Q12H w/ fat-containing foods ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| ☐ **Trikafta®** *(elexacaftor / tezacaftor / ivacaftor)* | TABLETS | ☐ 50 mg / 25 mg / 37.5 mg and 75 mg | ☐ 2 light orange Tabs PO in am & 1 light blue Tab in pm, Q12H w/ fat-containing foods ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| | | ☐ 100 mg / 50 mg / 75 mg and 150 mg | ☐ 2 orange Tabs PO in am & 1 light blue Tab in pm, Q12H w/ fat-containing foods ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| | GRANULES | ☐ 80 mg / 40 mg / 60 mg and 59.5 mg | ☐ 1 white / blue Pack in am & 1 white / green Pack in pm, 12H apart w/ fat-containing foods ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| | | ☐ 100 mg / 50 mg / 75 mg and 75 mg | ☐ 1 white / orange Pack in am & 1 white / pink Pack in pm, 12H apart w/ fat-containing foods ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| | | | | | |

| ORAL MEDICATIONS | | DOSE — Enzyme doses shown in units of Lipase | TREATMENT REGIMEN / DIRECTIONS | QTY | REFILLS |
|---|---|---|---|---|---|
| ☐ **Creon®** | USP | ☐ 3,000 ☐ 6,000 ☐ 12,000 ☐ 24,000 ☐ 36,000 | ☐ _____ w/ 3 meals & _____ w/ 4 snacks daily ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| ☐ **Pancreaze®** | USP | ☐ 2,600 ☐ 4,200 ☐ 10,500 ☐ 16,800 ☐ 21,000 ☐ 37,000 | ☐ _____ w/ 3 meals & _____ w/ 4 snacks daily ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| ☐ **Pertzye®** | USP | ☐ 4,000 ☐ 8,000 ☐ 16,000 ☐ 24,000 | ☐ _____ w/ 3 meals & _____ w/ 4 snacks daily ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| ☐ **Viokace Oral®** | USP | ☐ 10,440 ☐ 20,880 | ☐ _____ w/ 3 meals & _____ w/ 4 snacks daily ☐ Other: _____ | 1 month or _____ | 11 or _____ |
| ☐ **Zenpep®** | USP | ☐ 3,000 ☐ 5,000 ☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000 ☐ 40,000 ☐ 60,000 | ☐ _____ w/ 3 meals & _____ w/ 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.**

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***NOTE:*** *These products are only supplied by our pharmacy as treatment for Cystic Fibrosis. Forms without this diagnosis will be returned.*

Phone: 877.291.1122 • Fax: 877.291.1155

Date Shipment Needed: _____

# INHALED ANTIBACTERIALS FOR RECONSTITUTION REFERRAL FORM

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Patient Name: | | DOB: | Sex: ☐M ☐F ☐Other: | Weight: | ☐lbs. ☐kg. |
| SSN: | Phone: | Allergies: | | | |
| Address: | | City: | State: | Zip: | |
| Emergency Contact: | | Phone: | ☐**Additional Information Attached** | | |

## 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) ☐ E84.0 CF w/ Pul Man. _____ **Dx of Cystic Fibrosis required

- 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)**

## PRESCRIPTION INFORMATION (will dispense medication and supplies with standard directions, frequency, duration, quantity, and refills (marked in bold) unless otherwise indicated).

**Equipment (Select handset type for dispensing if necessary): ☐eRapid™ Nebulizer ☐PARI LC PLUS® Nebulizer (QTY. 1, use as directed with nebulized medications, refill 11** or_____.)

**Supplies: Syringes (any size appropriate) (QTY. 1 month** or _____, **use as directed, refills 6** or _____.) **Alcohol Swabs (Qty 1 month) Sharps Container (Qty 1)**

| MEDICATION (To Be Reconstituted And Inhaled Via Nebulizer By Mouth) | MIXING DIRECTIONS |
|---|---|
| ☐**Amikacin 250mg/4mL**<br>*Dispense amikacin 500mg/2mL(2mL) vial for inj. and sodium chloride 0.9% (10mL) vial for inj.* | **Mix 1mL (250mg) amikacin and 3mL sodium chloride 0.9% in nebulizer cup and nebulize 4mL (250mg) total.** |
| ☐**Amikacin 500mg/4mL**<br>*Dispense amikacin 500mg/2mL(2mL) vial for inj. and sodium chloride 0.9% (10mL) vial for inj.* | **Mix 2mL (500mg) amikacin and 2mL sodium chloride 0.9% in nebulizer cup and nebulize 4mL (500mg) total.** |
| ☐**Ceftazidime 500mg/4mL**<br>*Dispense ceftazidime 1g powder vial for inj. and sodium chloride 0.9% (10mL) vial for inj.* | **Reconstitute 1 vial ceftazidime 1g with 8mL sodium chloride 0.9% and nebulize 4mL (500mg).** |
| ☐**Ceftazidime 1000mg/5mL**<br>*Dispense ceftazidime 1g powder vial for inj. and sodium chloride 0.9% (10mL) vial for inj.* | **Reconstitute 1 vial ceftazidime 1g with 5mL sodium chloride 0.9% and nebulize 5mL (1g).** |
| ☐**Clindamycin 150mg/4mL**<br>*Dispense clindamycin 300mg/2mL(2mL) vial for inj. and sodium chloride 0.9% (10mL) vial for inj.* | **Mix 1mL (150mg) clindamycin and 3mL sodium chloride 0.9% in nebulizer cup and nebulize 4mL (150mg) total.** |
| ☐**Colistimethate 75mg/4mL**<br>*Dispense colistimethate 150mg powder vial for inj. and sodium chloride 0.9% (10mL) vial for inj.* | **Reconstitute 1 vial colistimethate 150mg with 8mL sodium chloride 0.9% and nebulize 4mL (75mg).** |
| ☐**Colistimethate 150mg/4mL**<br>*Dispense colistimethate 150mg powder vial for inj. and sodium chloride 0.9% (10mL) vial for inj.* | **Reconstitute 1 vial colistimethate 150mg with 4mL sodium chloride 0.9% and nebulize 4mL (150mg).** |
| ☐**Gentamicin 80mg/4mL**<br>*Dispense gentamicin 40mg/mL(2mL) vial for inj. and sodium chloride 0.9% (10mL) vial for inj.* | **Mix 2mL (80mg) gentamicin and 2mL sodium chloride 0.9% in nebulizer cup and nebulize 4mL (80mg) total.** |
| ☐**Gentamicin 120mg/4mL**<br>*Dispense gentamicin 40mg/mL(2mL) vial for inj. and sodium chloride 0.9% (10mL) vial for inj.* | **Mix 3mL (120mg) gentamicin and 1mL sodium chloride 0.9% in nebulizer cup and nebulize 4mL (120mg) total.** |
| ☐**Levofloxacin 100mg/5mL**<br>*Dispense levofloxacin 25mg/mL(20mL) vial for inj. and sodium chloride 0.9% (10mL) vial for inj.* | **Mix 4mL (100mg) levofloxacin and 1mL sodium chloride 0.9% in nebulizer cup and nebulize 5mL (100mg) total.** |
| ☐**Meropenem 250mg/5mL**<br>*Dispense meropenem 500mg powder vial for inj. and sterile water (10mL) vial for inj.* | **Reconstitute 1 vial meropenem 500mg with 10mL sterile water and nebulize 5mL (250mg).** |
| ☐**Meropenem 500mg/5mL**<br>*Dispense meropenem 500mg powder vial for inj. and sterile water (10mL) vial for inj.* | **Reconstitute 1 vial meropenem 500mg with 5mL sterile water and nebulize 5mL (500mg).** |
| ☐**Tobramycin 80mg/4mL**<br>*Dispense tobramycin 80mg/2mL(2mL) vial for inj. and sodium chloride 0.9% (10mL) vial for inj.* | **Mix 2mL (80mg) tobramycin with 2mL sodium chloride 0.9% in nebulizer cup and nebulize 4mL (80mg) total.** |
| ☐**Vancomycin 125mg/4mL**<br>*Dispense vancomycin 500mg powder vial for inj. and sodium chloride 0.9% (10mL) vial for inj.* | **Reconstitute 1 vial vancomycin 500mg with 16mL sodium chloride 0.9% and nebulize 4mL (125mg).** |
| ☐**Vancomycin 250mg/4mL**<br>*Dispense vancomycin 500mg powder vial for inj. and sodium chloride 0.9% (10mL) vial for inj.* | **Reconstitute 1 vial vancomycin 500mg with 8mL sodium chloride 0.9% and nebulize 4mL (250mg).** |
| ☐**Other (Include drug, diluent and final concentration)** | ☐**Other (Include mixing directions)** |

| FREQUENCY | DURATION | QUANTITY | REFILLS |
|---|---|---|---|
| **BID** or _____ | **Every Other Month** or _____ | **1 Month** or _____ | **6** 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.**





Rev: 04.27.22