**Cystic Fibrosis** 

**Prescription Referral Form** Bushnell: Phone: 1.352.793.8000 Fax: 1.352.793.8007

Wildwood:Phone: 1.352.748.9900

Fax: 1.352.748.9902





## www.safescriptpharmacy.com

1. Patient Information						
Patient Name:			SSN:		DOB:	
Address:			City:		ate:	Zip:
Home Phone:	Cell Phone:		[	Email Address:		
Sex: ☐ Male ☐ Female Heig	nt:	Weight:	☐ Ibs. ☐ kg.	Known Allergies	S:	
2. Insurance Information:						
Please fax front and back copy of all	Insurance cards (Pre	scription and	d Medical)			
3. Diagnosis/Clinical Information		·				
Please fax recent clinical notes, labs		rescription t	o expedite the Prio	r Authorization		
	CD 10:		Mutation (1*)	☐ Mutatio	on (2*)	
_			signing below, physicia			
4. Prescription Information: For IV medications attach a copy of your prescription						
4. Prescription information: For i	/ medications attach	a copy of yo	ur prescription			
☐ Kitabis Pak with Pari LC Plus nebulize	r	☐ Enroll Patient in PARI Provide Program		**Please use this section for additional directions or other medications not listed**		
	to obtain DeVilb	iss Pulmo-Aide	☐ OTHER:			
	•	Compressor		STRENGTH:		
		☐ DeVilbiss Pulmo-Aide Compressor (Q5 years)				
☐ Tobramycin nebulization ***Pari LC nebulizer:		r: tubing	DIRECTION	DIRECTIONS (SIG):		
□ TOBI recommended one tu		tube per inhale	d			
☐ TOBIPODHALER ☐ Colistimethate	treatment					
☐ Colistimethate Kit	Quantity:					
☐ Hyper-Sal  Replace tubing every 6 months?						
☐ Pulmozyme	□Yes □No	y o months:		Т.		
☐ Bethkis			QUANTITY: Start of The		REFILLS: Special Delivery	v Instructions:
☐ Kalydeco (lumacaftor) ☐ Kalydeco Oral Granules			Start of The	ару расе.	Special Delivery	y ilistructions.
□ Ralyueco Ofal Granules						
Therapy Ordered:	Anti-Infective Thera	† <i>*</i>	Nebulizers			
		Dose:				
	☐ Vancomycin					
	☐ Ceftriaxone	Frequency: Start Date:	Pancreatic Enz	vmes		
	•	Frequency:	Pancreatic Enz	ymes		
	☐ Ceftriaxone ☐ Cefepime	Frequency: Start Date:	Pancreatic Enz			
Labs (Vancomusin or Aminoglysosides)	☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Other: ☐ BMP, CBC w/ diff	Frequency: Start Date: Duration:  erential q Mone	day. Other Routine	ymes CF Medications		
Labs (Vancomycin or Aminoglycosides):	☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Other: ☐ BMP, CBC w/ diff ☐ Trough level after	Frequency: Start Date: Duration:  erential q Mone	day. Other Routine			
	☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Other: ☐ BMP, CBC w/ diff	Frequency: Start Date: Duration:  erential q Mone	day. Other Routine	CF Medications		
	☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Other: ☐ BMP, CBC w/ diff ☐ Trough level after routine Monday	Frequency:	day. Other Routine with	CF Medications		
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(Vancomycin or Aminoglycosides):  Flushing:  Ship to: □ Patient □ Office  5. Physician Information:  Prescriber Name:  Address:  Primary Office Contact:  Office Contact Email:  *I authorize Rosemont Specialty Pharmacy and it's repressagents, including the recipt of any required prior authorizes further authorize to forward	□ Ceftriaxone □ Cefepime □ Daptomycin □ Other: □ BMP, CBC w/ diff □ Trough level after routine Monday □ Other: □ NS 5 ml SASH and □ Heparin 20 units □ Heparin 100 units	Frequency: Start Date: Duration:  erential q Monor r 3rd dose and v d prn s SASH and prn  Prescribe City: Fax Numb	day.  Other Routine  Registered Oral Supple Tube Feedii Parenteral * A repr to coo  T NPI:  Oer:  Corriber, please sign and date belinge and initiate prior authorizallab values and other patient date adduct to another pharmacy of p	CF Medications  Fort  Dietitian Consult ments  Ing  Nutrition resentative from Coram C'rdinate your nutrition reference with the process for my patient(s), a. In the event that this pharmatient's choice or in the patient	DEA#:  e Number:  and to sign any necessary for nacy determines that it is unal nt's insurer's provider network	Zip:  rms on my behalf as authorized ble to fullfill this prescription, I
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This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.