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

SAFE SCRIPT PHARMACY
Bushnell | Wildwood
www.safescriptpharmacy.com

1. Patient Information

Patient Name:	SSN:	DOB:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email Address:	
Sex: ☐Male ☐Female	Height:	Weight: ☐ lbs. ☐ kg.	Known Allergies:

2. Insurance Information:

Please fax front and back copy of all Insurance cards (Prescription and Medical)

3. Diagnosis/Clinical Information:

Please fax recent clinical notes, labs, and tests with the prescription to expedite the Prior Authorization

Diagnosis:	ICD 10:	☐ 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

4. Prescription Information: For IV medications attach a copy of your prescription

☐ **Kitabis Pak with Pari LC Plus nebulizer**	☐ Enroll Patient in PARI Provide Program to obtain DeVilbiss Pulmo-Aide Compressor ☐ DeVilbiss Pulmo-Aide Compressor (Q5 years)	***Please use this section for additional directions or other medications not listed** ☐ OTHER: **STRENGTH:**
☐ **Tobramycin nebulization** ☐ **TOBI** ☐ **TOBIPODHALER** ☐ **Colistimethate** ☐ **Colistimethate Kit** ☐ **Hyper-Sal** ☐ **Pulmozyme** ☐ **Bethkis** ☐ **Kalydeco (lumacaftor)** ☐ **Kalydeco Oral Granules**	***Pari LC nebulizer: tubing recommended one tube per inhaled treatment Quantity: _____ Replace tubing every 6 months? ☐Yes ☐No	**DIRECTIONS (SIG):** **QUANTITY:** **REFILLS:** **Start of Therapy Date:** **Special Delivery Instructions:**
Therapy Ordered:	**Anti-Infective Therapy 1** ☐ Vancomycin ☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Other: Dose: _____ Frequency: _____ Start Date: _____ Duration: _____	**Nebulizers**
		Pancreatic Enzymes
Labs (Vancomycin or Aminoglycosides):	☐ BMP, CBC w/ differential q Monday. ☐ Trough level after 3rd dose and with routine Monday ☐ Other:	**Other Routine CF Medications**
Flushing:	☐ NS 5 ml SASH and prn ☐ Heparin 20 units ☐ Heparin 100 units SASH and prn	**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.

Ship to: ☐ Patient ☐ Office ☐ Other

5. Physician Information:

Prescriber Name:	Prescriber NPI:	DEA#:	
Address:	City:	State:	Zip:
Primary Office Contact:	Fax Number:	Phone Number:	
Office Contact Email:			

Prescriber Signature: Prescriber, please sign and date below

*I authorize Rosemont Specialty Pharmacy and it's representatives to act as my authorized agent to secure coverage and initaite prior authorization process for my patient(s), and to sign any necessary forms on my behalf as authorized agents, including the recipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fullfill this prescription, I further authorize to forward this information and any related to coverage of the product to another pharmacy of patient's choice or in the patient's insurer's provider network.

☐ Dispense as written ☐ Substitution Permissible

Prescriber's Signature _____ Date _____

This prescription is valid only if transmitted by facsimile machine by a licensed prescriber.