ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

URAC ACCREDITED SPECIALTY PHARMACY

Enroll via phone at: 800.906.7798
Enroll via fax at: 877.381.3806
E-prescribing NCPDP: 3982902
NPI: 1639103823 www.acropharmacy.com

RESPIRATORY ASSIST™ CYSTIC FIBROSIS ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 7.15.2018

COMMCARE SPECIALTY PHARMACY

URAC ACCREDITED SPECIALTY PHARMACY

Enroll via phone at: 888.203.7973
Enroll via fax at: 888.203.7980
E-prescribing NCPDP: 1079638
NPI: 1598762015 www.commcarepharmacy.com

Patient Demographics:(Please provide the following or attach demographics sheet)
Patient Name:_____
Address:_____
City, State, Zip:_____
Preferred Phone:_____ Alt. Phone:_____
Last four digits of SS#:_____ Date of Birth:_____
Gender:___ Allergies:_____Height:_____ Weight:_____

Provider Office: (Please provide as much information as possible)
Prescriber's Name:_____ Group/Hospital: _____
Specialty:_____ License#:_____Tax ID#:_____
Address:_____
NPI:_____ DEA:_____
City, State, Zip:_____
Phone:_____ Fax:_____ Office Contact:_____

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)

Medication Delivery to: (choose one) ☐Patient Address ☐Always to Physicians Office ☐First fill to Physician's Office, refills to Patient Address

Diagnostic Information: Diagnosis/ICD-10-CM Codes: ☐E84 Cystic Fibrosis ☐E84.8 Cystic Fibrosis w/ other manifestations ☐E84.11 Cystic Fibrosis w/ mention of meconium ileus ☐E84.19 Cystic Fibrosis w/ gastrointestinal manifestations ☐E84.9 Cystic Fibrosis, unspecified ☐Other_____

Prior Failed Medications:

DRUG NAME	*TRIAL DATE*	*THERAPEUTIC OUTCOME*
☐_____	_____	_____
☐_____	_____	_____

DRUG NAME	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐**Bethkis®** (tobramycin solution)	☐300 mg/4mL	☐Inhale contents of 1 vial (300 mg) via nebulizer every 12 hours for 28 days on, followed by 28 days off ☐Other_____	☐4 week supply ☐Other:_____	
☐**Kitabis Pak®** (tobramycin solution)	☐300 mg/5mL	☐Inhale contents of 1 vial (300 mg) via nebulizer every 12 hours for 28 days on, followed by 28 days off ☐Other_____	☐4 week supply ☐Other:_____	
☐**TOBI®** (tobramycin solution)	☐300 mg/5mL	☐Inhale contents of 1 vial (300 mg) via nebulizer every 12 hours for 28 days on, followed by 28 days off ☐Other_____	☐4 week supply ☐Other:_____	
☐**TOBI Podhaler®** (tobramycin solution)	☐28 mg capsules	☐Inhale 4 capsules via the Podhaler device every 12 hours for 28 days, then off for 28 days ☐Other_____	☐4 week supply ☐Other:_____	
☐**Pulmozyme®** (dornase alfa)	☐2.5 mg (1mg/mL)	☐Inhale contents of 1 vial (2.5 mg) via nebulizer once daily ☐Other_____	☐1 month supply (30 vials) ☐Other:_____	
☐**Other**				
☐**Other**				

Unless otherwise noted this prescription authorizes Acro and Commcare to dispense & share information between each other to optimize care delivery. Check here to restrict to ☐Acro ☐Commcare

Physician Signature:_____ ☐DAW (Dispense as Written) **Date:**_____

Patient Support Programs: I authorize **Acro Pharmaceutical Services and Commcare Specialty Pharmacy** to enroll me in company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis or other commercial purposes, and provide educational information regarding therapies. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above. A copy of this authorization will be utilized with same effectiveness as an original. Ancillary supplies provided as needed for administration.

***Patient Signature:** (required for participation)_____ Date:_____ ☐ Please select if you would like the patient enrolled in a Manufacturer's Assistance Program