



RESPIRATORY ASSIST™ CYSTIC FIBROSIS ENROLLMENT FORM



Enroll via phone at: 800.906.7798
 Enroll via fax at: 877.381.3806
 E-prescribing NCPDP: 3982902
 NPI: 1639103823

www.acropharmacy.com

Last update 7.15.2018

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
<input type="checkbox"/> _____	_____	_____
<input type="checkbox"/> _____	_____	_____

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

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