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RESPIRATORY ASSIST™ ENROLLMENT FORM

Today's Date: _____
 Needed By: _____

Last update 12.18.2018



www.commcarepharmacy.com
 Plantation, FL
 Phone: 888.203.7973
 Fax: 888.203.7980
 NCPDP: 1079638
 NPI: 1598762015

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's Address Always to Physician's Office First fill to Physician's Office, refills to Patient's Address

Diagnostic Information: Diagnosis (Please provide ICD-10-CM codes)

- J45.40 Moderate persistent asthma, uncomplicated E84 Cystic Fibrosis
 J45.50 Severe persistent asthma, uncomplicated Other: _____
 J84.112 Idiopathic pulmonary fibrosis
 J44.9 Chronic obstructive pulmonary disease, unspecified

Clinical Information: Please attach/send recent progress notes

Previous Therapies:

Asthma Medications:

	Dose & Directions: (please specify loading dose where applicable)	Quantity	Refills
<input type="checkbox"/> Dupixent® (dupilumab)			
<input type="checkbox"/> Xolair® (omalizumab)			

Chronic Obstructive Pulmonary Disease Medications:

	Dose & Directions:	Quantity	Refills
<input type="checkbox"/> Lonhala Magnair™ (glycopyrrolate)			

Cystic Fibrosis Medications:

	Dose & Directions:	Quantity	Refills
<input type="checkbox"/> Bethkis® (tobramycin solution)			
<input type="checkbox"/> Kitabis® (tobramycin solution)			
<input type="checkbox"/> TOBI® (tobramycin solution)			
<input type="checkbox"/> TOBI Podhaler® (tobramycin solution)			
<input type="checkbox"/> Pulmozyme® (dornase alfa)			

Idiopathic Pulmonary Fibrosis Medications:

	Dose & Directions: (please specify loading dose where applicable)	Quantity	Refills
<input type="checkbox"/> Esbriet® (pirfenidone) <input type="checkbox"/> Capsules <input type="checkbox"/> Tablets			
<input type="checkbox"/> Ofev® (nintedanib)			

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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