ACRO PHARMACEUTICAL SERVICES
A PREMIER INC. COMPANY

www.acropharmacy.com

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RESPIRATORYASSIST™ ENROLLMENT FORM

Today's Date:_____
Needed By:_____

Last update 12.18.2018

COMMCARE SPECIALTY PHARMACY
A PREMIER INC. COMPANY

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:			
□Dupixent®(dupilumab) □Xolair®(omalizumab)	Dose & Directions: *(please specify loading dose where applicable)*	Quantity	Refills
Chronic Obstructive Pulmonary Disease Medications:			
□Lonhala Magnair™ (glycopyrrolate)	Dose & Directions:	Quantity	Refills
Cystic Fibrosis Medications:			
□Bethkis® (tobramycin solution) □Kitabis® (tobramycin solution) □TOBI® (tobramycin solution) □TOBI Podhaler® (tobramycin solution) □Pulmozyme® (dornase alfa)	Dose & Directions:	Quantity	Refills
Idiopathic Pulmonary Fibrosis Medications:			
□Esbriet®(pirfenidone) □Capsules □Tablets □Ofev®(nintedanib)	Dose & Directions: *(please specify loading dose where applicable)*	Quantity	Refills

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