



Patient Information

last name, _____ first name _____ m female ") \ " _____ OO _____
 (street, apt, city, state, zip) _____ alternate phone number: _____ cell _____
 caregiver: _____ allergies: _____ NKDA _____
 comorbidities: _____ height: _____ weight: _____ lbs kg date: _____

Clinical Information

Diagnosis/ICD-9		CFTR gene mutations			Other conditions
277.00 CF without meconium ileus	277.03 CF with GI manifestations	F508del/ F508del <i>(homozygous)</i>	G551S R117H S1251N	Other (Please specify): _____	Pancreatic Insufficiency CFRD Osteoporosis Liver Disease Depression Other: _____
277.01 CF with meconium ileus	277.09 CF with other manifestations	G1244E G1349D G178R G551D	S1255P S549N S549R		
277.02 with pulmonary manifestations	V83.81 CF gene carrier				

Prescription	Dose	Directions	Quantity	Refills
Bethkis®	300 mg ampule	Inhale the entire contents of the ampule twice daily for 28 days on, followed by 28 days off	1 box (56 ampules)	
Kalydeco®	150 mg tablet	Take one tablet by mouth every 12 hours with fat-containing food	60 tablets	
	50 mg packet of oral granules (wt. < 14 kg) 75 mg packet of oral granules (wt. ≥ 14 kg)	Take one packet mixed with one teaspoon (5mL) of age-appropriate food or liquid by mouth every 12 hours with fat-containing food.	56 packets	
Kitabis® Pak	300 mg/ 5 mL ampule	Inhale the entire contents of one ampule twice daily for 28 days on, followed by 28 days off	1 box (56 ampules)	
Orkambi™ <small>(lumacaftor/ivacaftor)</small>	200 mg/125 mg	Take 2 tablets by mouth every 12 hours with fat-containing food	112 tablets	
Pulmozyme®	2.5 mg ampule	Inhale the contents of one ampule via nebulizer once daily Inhale the contents of one ampule via nebulizer twice daily	1 box (30 ampules) 2 boxes (60 ampules)	
TOBI® <small>(tobramycin inhaled solution)</small>	300 mg ampule	Inhale the contents of one ampule via nebulizer twice daily (every 12 hours) for 28 days on, followed by 28 days off	1 box (56 ampules)	
TOBI® Podhaler™	28 mg capsule	Inhale the contents of four capsules twice daily (every 12 hours) for 28 days on, followed by 28 days off	1 box (224) capsules	

prescriber signature required for manufacturer support training Physician's office Manufacturer support needed No nurse support needed

Prescriber + Shipping Information

prescriber (print): _____ office contact: _____
 preferred method of contact: phone fax email preferred contact persons email: _____
 ship to: patient office alternate shipping address: _____ street _____ city _____ state _____ zip _____
 office address: _____
(street, suite, city, state, zip)
 phone: _____ fax: _____ NPI: _____ DEA: _____
 prescriber's signature: _____ date: _____
I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Insurance Information: please fax copy of insurance card (front + back)

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