Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy

AccuSERV® PHARMACY

Cystic Fibrosis Enrollment Form

Clear Form

Fax: (877) 526-8823

Pharmacy Phone: (866) 213-9821

Single Point of Contact: (724) 515-7053

Start Date:_____ **Ship to:** ☐ Patient ☐ Office ☐ Other:_____

1. Patient Information

Patient Name:_____ ◯Male ◯Female

Address:_____

DOB: _____ SSN: _____ Caregiver:_____

Phone#:_____ Alt Phone#:_____Weight:_____ Height:_____

Allergies: _____ Comorbidities: _____

2. Clinical Information *Please fax recent clinical notes, labs & tests with prescription to expedite the prior authorization*

ICD -10/ Diagnosis Code:_____ Mutations:_____

Prior Therapy: _____ Reason for Discontinuation: _____

Concomitant Medications: _____

3. Prescription Information *If your selection (Medication/ Directions/ QTY) is not shown below please write it in the space provided*

✘	Medication	Dose / Strength	Directions *(be specific)*	Quantity	Refills
	Bethkis®	◯300mg/4mL	◯Inhale 300mg every 12 hrs via nebulizer for 28 days on, followed by 28 days off	◯56 ampules	
	Kitabis Pak®	◯ 300mg/5mL	◯Inhale contents of 1 ampule with nebulizer every 12 hrs for 28 days. Followed by 28 days off drug. ◯	◯56 ampules ◯112 ampules ◯	
	TOBI®	◯300mg/5mL	◯Inhale 300mg every 12 hrs via nebulizer for 28 days on, followed by 28 days off	◯56 ampules	
	TOBI Podhaler®	◯28mg	◯Inhale 112mg (4 capsules) every 12 hrs for 28 days on, followed by 28 days off	◯224 capsules	
	Pulmozyme®	◯2.5mg/2.5mL	◯Inhale 2.5mg orally once daily via nebulizer ◯Inhale 2.5mg orally twice a day via nebulizer	◯30 ampules ◯60 ampules	

4. Prescriber and Shipping Information

Prescriber (print): _____ Office Contact: _____

Pref. Method of Contact: ◯phone ◯fax ◯email Contact email:_____

Office Address: _____

Phone:_____ Fax: _____

NPI: _____ DEA: _____

Prescriber's Signature: _____ Date:_____

I authorize AccuServ Pharmacy and its representative to act as an agent to initiate and execute the insurance prior authorization process. (NO STAMPS)

5. Insurance Information **Please fax a copy of insurance card front and back. Enlarge if possible.**

Please fax completed form to AccuServ Pharmacy at (877) 526-8823. Visit us at WWW.ACCUSERVPHARMACY.COM for online fillable forms.