MORRISTOWN PHARMACY

CYSTIC FIBROSIS PRESCRIPTION FORM

95 Madison Ave #110 | Morristown, NJ, 07960
Tel: 973 - 998 - 0287 | Fax: 973 - 998 - 0288

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date ______ Anticipated Start Date ______

☐ **NEW PATIENT** ☐ **CURRENT PATIENT**

Last updated: May 2017

Patient Name ______ First Name ______ Middle Name ______ Last Name ______ DOB______ Weight______ ☐ Male ☐ Female

Street Address ______ Apt # ______ City ______ State ______ Zip ______

Daytime Tel______ Evening Tel______ Cell ______ Email ______

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed ______

ICD-10 Code ☐ E84.9 Cystic Fibrosis Blood Glucose test (if >14 y/o)______ Most Recent PFT%______ Allergies ______

Other Conditions: ☐ Pancreatic Insufficiency ☐ CFRD ☐ Osteoporosis ☐ Liver Diesase ☐ Depression ☐ Other______

Is *Pseudomonas aeruginosa* present in airway cultures? ☐ Yes ☐ No Concomitant Medications ______

Insured's Name______ Relation to Patient ______ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# ______

Prescription Card ☐ Yes ☐ No If Yes, Carrier ______ Tel ______ Fax ______ Policy/Group# ______

Bin# ______ Pcn# ______ RXID# ______ RX Group# ______

Prescriber's Name ______ Office Contact ______

Street Address ______ Suite # ______ City ______ State ______ Zip ______

Tel ______ Fax ______ Email ______

License# ______ NPI# ______ UPIN# ______ DEA# ______

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **COLISTIMETHATE**

☐ **COLISTIMETHATE KIT** *included as needed*
contains sterile water for injection, syringes, needles and sharps container

☐ **HYPER-SAL®** 7%

☐ **KALYDECO** 150mg
SIG: Take 1 tab every 12 hours orally

☐ **PULMOZYME®** 2.5mg

☐ **TOBI®** 300mg *Pari LC Nebulizer tubing recommended*
1 tube per inhaled treatment Quantity:______
Replace tubing every 6 months: ☐ Yes ☐ No

SIG ______

Quantity______ Refill______

NEBULIZER

☐ **PARI LC PLUS®** Use as directed with compressor.
Replace tubing every 6 months (Manufacturer and CF Foundation recommendation)
SIG ______ Quantity______ Refill______

PANCREATIC ENZYMES

CREON®
☐ Creon®5 ☐ Creon®10 ☐ Creon® 20

ZENPEP®
☐ Zenpep® 5 ☐ Zenpep® 10 ☐ Zenpep® 15 ☐ Zenpep® 20

PANCREAZE®
☐ Pancreaze® 4 ☐ Pancreaze® 10 ☐ Pancreaze® 16 ☐ Pancreaze® 20

SIG ______ Quantity______ Refill______

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS) ______ **Date** ______

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Please fax completed form to **Morristown Pharmacy** at **973 - 998 - 0288** Visit us at **WWW.MORRISTOWNRX.COM** for online fillable forms.

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