BLUEGRASS PHARMACY | CYSTIC FIBROSIS ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the Wellpartner Family

FAX FORM TO: 1.866.233.8317 | **PHONE:** 1.855.492.0817 | **EMAIL:** contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:
Address:
City, State, ZIP:
Primary Phone: - - DOB: / /
Alternate Phone: - - Gender:
Email:
Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:
DEA #: NPI #: State Lic. #:
Group or Hospital:
Address:
City, State, Zip:
Phone: - - Fax: - -
Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:
Primary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

Secondary Insurance Company Name:
Secondary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / /
Ship to: ◯ Patient ◯ Office ◯ Other:
Date of Diagnosis: / /
Patient has genetic marker: ◯ G551D ◯ f508del ◯ Other:
◯ E84.9 Cystic fibrosis
◯ Other: _____
Allergies:
Current Medications:

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Colistimethate kit (includes sterile water for injection, syringes, needles, and sharps container)				
◯ Hyper-Sal®	7%			
◯ Kalydeco	150 mg	Take 1 tablet by mouth twice daily.		
◯ Pulmozyme®	2.5 mg			
◯ TOBI® (LD)*	(LD)* These are limited distribution drugs that require additional handling. Please call (1.855.492.0817) for more information.			
◯ TOBIPODHALER (LD)*				
◯ Bethkis® (LD)*				
◯ Orkambi®	200mg-125mg tablet	Take 2 tablets by mouth every 12 hours with fat containing food.		
◯				
◯				
◯				
◯				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE