WELLPARTNER PHARMACY | CYSTIC FIBROSIS ENROLLMENT FORM

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.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 (1.800.473.3516) 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