aleracare
advanced specialty pharmacy

Cystic Fibrosis
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Client Considerations

Diagnosis (ICD 10):
- ◯ E84.0 Cystic fibrosis with pulmonary manifestations
- ◯ E84.11 Meconium ileus in cystic fibrosis
- ◯ E84.19 Cystic fibrosis with other intestinal manifestations
- ◯ E84.8 Cystic fibrosis with other manifestations
- ◯ E84.9 Cystic fibrosis, unspecified
- ◯ Other (please specify):_____

Other Conditions: ◯ Pancreatic Insufficiency ◯ CFRD ◯ Osteoporosis ◯ Liver Disease ◯ Depression

Blood Glucose Test (If > 14 yo): _____(fasting) _____(non-fasting)

Most Recent PFT%: _____

Is Pseudomonas Aeruginosa present in airway culture? ◯ Yes ◯ No

Medication	Dose/Strength	Directions for Use	Qty	Refills
◯ **BETHKIS®** (Tobramycin Inhalation Solution)	◯ 2.5mg			
◯ **CAYSTON®** (Aztreonam)				
◯ **HYPER-SAL®** (NaCl Inhalation)	◯ 7%			
◯ **KALYDECO®** (Ivacaftor)	◯ 150mg			
◯ **KITABIS® PAK** (Tobramycin Inhalation Solution)				
◯ **ORKAMBI™** (Lumacaftor/Ivacaftor)				
◯ **PULMOZYME®** (Dornase Alpha)				
◯ **TOBI®** (Tobramycin)	◯ 300mg			

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature _____ **Date** _____