CYSTIC FIBROSIS PRESCRIPTION REFERRAL FORM

REALO SPECIALTY CARE PHARMACY

Community Consultant Contact:

Fax referral to: 844-814-1944 Phone: 844-814-1943
Email referral form to: connect@realospecialtycare.com
For additional forms, visit realospecialtycare.com.

PATIENT INFORMATION

Patient Name: _____ ❑Male ❑Female SS#: _____ DOB: _____
Address: _____ City, State, Zip: _____
Primary Phone: _____ ❑Home ❑Cell ❑Work Alternate Phone: _____ ❑Home ❑Cell ❑Work
Email: _____ Height: _____ Weight: _____
Allergies: _____ Comorbidities: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Office Contact: _____
Address: _____ City, State, Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____

SHIPPING INFORMATION

Ship To: ❑Patient ❑Phvsician/Clinic ❑Realo Location: _____
Date Shipment Needed By: _____ ❑Alternate Location: _____
Shipping Address City, State, Zip

DIAGNOSIS AND CLINICAL INFORMATION (Please send clinical notes, labs, and/or other supporting documents)

Diagnosis ICD-9: ❑277.00 CF without meconium ileus ❑277.01 CF with meconium ileus ❑277.02 with pulmonary manifestations
❑277.03 CF with GI manifestations ❑277.09 CF with other manifestation ❑V83.81 CF gene carrier
CFTR Gene Mutations: ❑F508del ❑G1244E ❑G1349D ❑G178R ❑G551D ❑G551S ❑S1251N ❑S1255P ❑S549R ❑Other (Please specify): _____
Other Conditions: ❑Pancreatic Insufficiency ❑CFRD ❑Osteoperosis ❑Liver Disease ❑Depression
❑Other: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE	QUANTITY	REFILLS	DIRECTIONS
❑Bethkis®	300 mg ampule	1 box (56 ampules)		Inhale the entire contents of the ampule twice daily (every 12 hours) for 28 days on, followed by 28 days off
❑Kitabis® Pak	300 mg / 5 mL ampule	1 box (56 ampules)		Inhale the entire contents of one ampule twice daily (every 12 hours) for 28 days on, followed by 28 days off
❑Pulmozyme®	2.5 mg ampule	❑1 box (30 ampules)		❑Inhale contents of one ampule via nebulizer once daily
		❑2 boxes (60 ampules)		❑Inhale contents of one ampule via nebulizer twice daily
❑tobramycin inhaled solution	300 mg ampule	1 box (56 ampules)		Inhale the contents of one ampule via nebulizer twice daily (every 12 hours) for 28 days on, followed by 28 days off
❑Creon®	Lipase Unit Capsules: ❑3000 ❑6000 ❑12000 ❑24000 ❑36000			Take listed number of capsules per meal/snack whole or sprinkled capsule(s) on a small amount of acidic soft food immediately by mouth with water, juice, or other liquid.
❑Pancreaze®	Lipase Unit Capsules: ❑2600 ❑4200 ❑10500 ❑16800 ❑21000			Do not mix directly into infant formula or breast milk. Do not crush or chew capsule shell or contents.
❑Pertzye®	Lipase Unit Capsules: ❑4000 ❑8000 ❑16000 ❑24000			Breakfast: _____ Dinner: _____ Lunch: _____ Snacks: _____
❑Zenpep®	Lipase Unit Capsules: ❑3000 ❑5000 ❑10000 ❑15000 ❑20000 ❑25000 ❑40000			

Prescriber Signature: I authorize Realo Specialty Care Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Dispense As Written - Signature	Date	Substitution Permissable - Signature	Date

PLEASE FAX COPY OF INSURANCE CARD (FRONT + BACK) AND MEDICATION LIST TO 844-814-1944.