Cystic Fibrosis
Support Medications

Phone: 877.977.9118
Fax: 866.376.1448

Patient Information

Patient name: __________________________ DOB: ______________
Sex: ❑ Female ❑ Male SSN: ________________________________
Language: ____________Wt: _____ ❑kg ❑lbs Ht: _____❑cm ❑in
Address: ____
Apt/Suite: _____ City: _________________ State: _____ Zip: _____
Phone: ____________________ Alternate: ____________________
Caregiver name: _____________________ Relation: ______________
Local pharmacy: ______________________ Phone: ______________
Insurance plan: __________________ Plan ID: __________________
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: ____
NPI: ____
Address: ____
Apt/Suite: ______ City: _____________ State: _______ Zip: ______
Contact: ____
Phone: ______________________ Alternate: ___________________
Fax: ____
Email: ____
If shipping to prescriber: ❑ First Fill ❑ Always Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ E84.0 (pulmonary manifestations) ❑ E84.11 (meconium ileus) ❑ E84.19 (gastrointestinal manifestations)
❑ E84.8 (other manifestations) ❑ E84.9 (unspecified)

Mutations: ❑ F508del ❑ G1244E ❑ G1349D ❑ G178R ❑ G551D ❑ G551S ❑ R117H ❑ S1251N ❑ S549N ❑ S549R ❑ S1255P
❑ Other ____

Prior Therapy ❑ Yes ❑ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
____________________	______________________________	______________	______________
____________________	______________________________	______________	______________
____________________	______________________________	______________	______________

Comorbidities: ____
Concomitant Medications: ____
Allergies: ❑ NKDA ❑ Other: ____

Prescription	Directions	Dosage/Quantity	Refill
❑ **Aquadeks**			_____
❑ **Multivitamins**			_____
❑ **Creon®**	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. Do not mix directly into infant formula or breast milk. Do not crush or chew capsule shell or contents. Breakfast: ________ capsules Lunch: ________ capsules Dinner: ________ capsules Snacks: ________ capsules	❑ ______ x 6,000 lipase unit capsules ❑ ______ x 12,000 lipase unit capsules ❑ ______ x 24,000 lipase unit capsules ❑ ______ x 36,000 lipase unit capsules	_____
❑ **Pancreaze®**		❑ ______ x 16,800 lipase unit capsules ❑ ______ x 21,000 lipase unit capsules	_____
❑ **Pertzye®**		❑ ______ x 8,000 lipase unit capsules ❑ ______ x 16,000 lipase unit capsules	_____
❑ **Zenpep®**		❑ ______ x 10,000 lipase unit capsules ❑ ______ x 15,000 lipase unit capsules ❑ ______ x 20,000 lipase unit capsules ❑ ______ x 25,000 lipase unit capsules ❑ ______ x 40,000 lipase unit capsules	_____

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: __________________________

Prescriber's Signature:____ Date: _______________

I authorize Diplomat Pharmacy, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc.

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