

### 1 PATIENT INFORMATION

Patient's Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  Male  Female  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Parent/Guardian (if applicable) \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_  
Phone No. \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Identification No. \_\_\_\_\_ Policy/Group No. \_\_\_\_\_  
Prescription Card  No  Yes If Yes, Carrier \_\_\_\_\_  
Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_  
Is patient eligible for Medicare?  No  Yes **Please attach copies of patient's insurance cards, if available.**

### 2 PRESCRIBER INFORMATION

Prescriber's Name \_\_\_\_\_  
Office Contact \_\_\_\_\_  
Clinic / Hospital Affiliation \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
E-mail address \_\_\_\_\_  
NPI No. \_\_\_\_\_ License No. \_\_\_\_\_  
DEA No. \_\_\_\_\_  
Physician Medicaid UPIN No. \_\_\_\_\_  
**MD Specialty** \_\_\_\_\_

To reach your team, call toll-free 1.888.608.9010.  
**Please fax completed form to the Cystic Fibrosis team**  
**1.888.302.1028.**



### 3 CLINICAL INFORMATION

Primary ICD-9 Code: \_\_\_\_\_

#### Rx:

Pulmozyme® (dornase alfa)

SIG: Dose: \_\_\_\_\_ mg for inhalation using recommended nebulizer

Frequency: \_\_\_\_\_

Dispense Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

NKDA

Known Drug Allergies: \_\_\_\_\_

Tobi® (tobramycin)

SIG: Dose: \_\_\_\_\_ mg for inhalation using recommended nebulizer

Frequency: \_\_\_\_\_

Dispense Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

NKDA

Known Drug Allergies: \_\_\_\_\_

Deliver product to:  Office  Patient's Home  Clinic Clinic Location

If shipped to physician's office, physician accepts on behalf of patient for administration in office

*By signing below, I certify that the above therapy is medically necessary.*

Prescriber's Printed Name \_\_\_\_\_

Prescriber's Signature (sign below) \_\_\_\_\_ Date \_\_\_\_\_

Dispense as Written

Substitution Allowed

(Physician attests this is his/her legal signature. **NO STAMPS**)