## **Cystic Fibrosis Enrollment Form - Oral Therapies**



Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727 NCPDP: 1203417

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|  |   |   |  |   |  |
| SIRENGIA   |   | DOSE & DIRECTIONS   |  | OHANTITY / DEELLIS  |  |
| mg/20mg/50mg tablet  |   |   |  | QUANTITY/REFILLS  1-Month supply  |  |
| Omg/50mg/125mg tablet  | Take 3 tablets by mouth with fat-containing food.  Take 2 tablets by mouth with fat-containing food.  |   | 3-Month supply   |   |  |
| ggg  | Other   |   |  | Other   |  |
|  |   |   |  |   |  |
|  |   |   |  | Refills   |  |
|  |   |   |  |   |  |
| 50 ma tablats  | ☐ Take 1 tablet by mouth every 12 hours with fat-containing food. ☐ Other   |   | 1-Month supply 3-Month supply Other  |   |  |
| oo mg tablets  |   |   |  |   |  |
|  | (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)  Mix 1 packet of granules in one teaspoon (5mL) of soft food or liquid and                                     |   |  |   |  |
|  |   |   |  |   |  |
|  | I — '   |   |  |   |  |
|  |   |   |  |   |  |
|  |   |   |  |   |  |
| <u> </u>   |   |   |  |   |  |
| 00mg/125mg tablet  | ☐ Take 2 tablets by mouth   | A Manth   |  |   |  |
| 00mg/125mg tablet  | Other   |   |  | 1-Month supply 3-Month supply Other   |  |
| 5mg/94mg granules  |   |   |  |   |  |
| 00mg/125mg granules  |   |   |  |   |  |
| 50mg/188mg granules  |   |   |  | Refills   |  |
|  |   |   |  |   |  |
| S DDESCRIBED SIGN  |   |   |  | <u> </u>  |  |
|  |   |   |  |   |  |
| nd Medically Necessary / Do Not  | Substitute / No Substitution /  |   | ction Permitted /  |   |  |
| re:  | Date:   |   | <b></b>  | Date:   |  |
| ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )  | 500mg/125mg tablet<br>5mg/94mg granules<br>50mg/125mg granules<br>50mg/188mg granules<br>6 PRESCRIBER SIGN<br>and Medically Necessary / Do Not  | Take 1 tablet by mouth en   | [i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibited by mouth every 12 hours with fat-contain Other [i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibited by mouth every 12 hours with fat-containing food.  By mg granules administer every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing food.  Take 2 tablets by mouth every 12 hours with fat-containing f | [i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.]    Take 1 tablet by mouth every 12 hours with fat-containing food.   Other |  |

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

## Cystic Fibrosis Enrollment Form - Oral Therapies

| Octiont Name:  |   | se Complete Patient and F   |   |   |  |  |
|--|---|---|---|---|--|--|
|  | e:  |   | Patient Phone:<br>escriber Phone:   |   |  |  |
|  | ON INFORMATION  |   | escriber Friorie.   |   |  |  |
| Symdeko (tezacaftor/ ivacaftor + ivacaftor)  | 50mg/75mg tablet + 75mg tablet  | Take 1 white tablet in the morning approximately 12 hours apart with 1 Other  (i.e. dose adjustments for hepatic impairment and more) |   | ☐ 1-Month supply ☐ 3-Month supply ☐ Other |  |  |
|  | 100mg/150mg tablet + 150mg tablet   | Take 1 yellow tablet by mouth in evening approximately 12 hours ap Other (i.e. dose adjustments for hepatic impairment and m          | Refills   |   |  |  |
| ☐ Trikafta<br>(elexacaftor/<br>tezacaftor/<br>ivacaftor +<br>ivacaftor)  | 50mg/25mg/37.5mg tablet + 75mg tablet 100mg/50mg/75mg tablet + 150mg tablet | evening approximately 12 hours ap   | in the morning, and 1 blue tablet in the art with fat-containing food.  Oderate to strong CYP3A inhibitors; please see package insert.) |   |  |  |
|  | 80mg/40mg/60mg + 59.5mg oral granules                                       |   | ☐ 1-Month supply ☐ 3-Month supply ☐ Other  Refills  |   |  |  |
|  | 100mg/50mg/75mg<br>+ 75mg oral granules                                     |   |   |   |  |  |
|  | •   |   |   |   |  |  |
| ncreatic Enzyn   | 3,000   6,000   12,000   24,000   36,000                                    |   | Takewith meals with snacks.  Max per day  | Quantity: Refills:                        |  |  |
| Pancreaze  |   |   | Takewith meals with snacks.  Max per day  | Quantity: Refills:                        |  |  |
| Pertzye  | □ 8,000 □ 16,000  |   | Takewith meals with snacks.  Max per day  | Quantity: Refills:                        |  |  |
| Viokase  | □ 10,440 □ 20,880   |   | Takewith meals with snacks.  Max per day  | Quantity: Refills:                        |  |  |
| Zenpep   | ☐ 3,000 ☐ 5,000 ☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000 ☐ 40,000                |   | Takewith meals with snacks.  Max per day  | Quantity: Refills:                        |  |  |
|  | 6 PRESCRIBER S  | STAMP SIGNATURE NO<br>SIGNATURE REQUIRED (ST  | Ancillary supplies and kits provident ALLOWED  AMP SIGNATURE NOT ALLOWE   |   |  |  |
| "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute  Prescriber's Signature:  Date: |   |   | May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:   | Date:                                     |  |  |
|  |   | riber writes the words "No Substitution"  | ATTN: New York and Iowa providers, please submit electronic prescrip  |   |  |  |

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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