Cystic Fibrosis Enrollment Form - Oral Therapies



Fax Referral To: 1-844-823-5480

Email Referral To: Customer.ServiceFax@CVSHealth.com Six Simple Steps to Submitting a Referral PATIENT INFORMATION (Complete or include demographic sheet) DOB: _____ Gender: Male Female _____City, State, ZIP Code: Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below) Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone. ___ Alternate Phone: ___ Last Four of SSN: _____ Primary Language: _____ Email: Parent/Caregiver/Legal Guardian Name (Last, First): _______Relationship to patient: ______ 2 PRESCRIBER INFORMATION State License #: Prescriber's Name: NPI #: _____ DEA #: _____ Group or Hospital: _____ Address: _____ City, State, ZIP Code: _____ Phone: ____ Fax ___ Contact Person: ____ Contact's Phone: _____ INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back) 4 DIAGNOSIS AND CLINICAL INFORMATION Needs by Date: _____Ship to: Patient Office Other: ____ Diagnosis (ICD-10): ☐ E84.0 Cystic Fibrosis ☐ E84.8 CF w/ other manifestations ☐ E84.19 CF w/ intestinal manifestations Other Code: ______ Description _____ CFTR Mutation (1) CFTR Mutation (2) Patient Clinical Information: ____ Weight: ___lb/kg Height: ___in/cm Allergies: 5 PRESCRIPTION INFORMATION **MEDICATION** STRENGTH DOSE & DIRECTIONS **QUANTITY/REFILLS** 4mg/20mg/50mg tablet ☐ Take 3 tablets by mouth with fat-containing food. ☐ 1-Month supply 10mg/50mg/125mg tablet ☐ Take 2 tablets by mouth with fat-containing food. 3-Month supply ☐ Alyftrek (vanzacaftor/ Other Other (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.) tezacaftor/ Refills ____ deutivicaftor) 150 mg tablets Take 1 tablet by mouth every 12 hours with fat-containing food. 1-Month supply Other (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.) 3-Month supply 5.8 mg granules Mix 1 packet of granules in one teaspoon (5mL) of soft food or liquid and Other (ivacaftor) 13.4 mg granules administer every 12 hours with fat-containing food. Other 25 mg granules Refills _____ (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.) 50 mg granules 75 mg granules 100mg/125mg tablet ☐ Take 2 tablets by mouth every 12 hours with fat-containing food. 1-Month supply 200mg/125mg tablet Other Orkambi 3-Month supply (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.) Other (lumacaftor/ 75mg/94mg granules ivacaftor) 100mg/125mg granules Mix 1 packet of granules in one teaspoon (5mL) of soft food or liquid and Refills _____ 150mg/188mg granules administer every 12 hours with fat-containing food. Other (i.e. dose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.) 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED) "Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / May Substitute / Product Selection Permitted / DAW / May Not Substitute Substitution Permissible

Prescriber's Signature: _ $\textbf{CA, MA, NC \& PR}: Interchange is mandated unless Prescriber writes the words "\textbf{No Substitution}" _$ Prescriber's Signature: _

__ ATTN: New York and Iowa providers, please submit electronic prescription

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

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Octiont Name:		se Complete Patient and F	Prescriber Information Patient Phone:		
	e:		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	evening approximately 12 hours ap	Take 1 yellow tablet by mouth in the morning, and 1 blue tablet in the ning approximately 12 hours apart with fat-containing food. Other ose adjustments for hepatic impairment and moderate to strong CYP3A inhibitors; please see package insert.)		
☐ Trikafta (elexacaftor/ tezacaftor/ ivacaftor + 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.)	☐ 1-Month supply ☐ 3-Month supply ☐ Other Refills	
	80mg/40mg/60mg + 59.5mg oral granules	the morning. Mix 1 green packet in and take in the evening. Take with apart.	on (5mL) of soft food or liquid and take in one teaspoon (5mL) of soft food or liquid fat-containing food approximately 12 hours		
	100mg/50mg/75mg + 75mg oral granules	the morning. Mix 1 pink packet in o take in the evening. Take with fat-capart.			
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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 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:			May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature:	Date:	
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution"			ATTN: New York and Iowa providers, please submit electronic prescripti		

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