



**CYSTIC FIBROSIS MEDICATION**

Prior Authorization/Prescription/Patient Enrollment Form  
Complete form in its entirety and fax to number listed below

Please Note: Cayston® and pancreatic enzymes are not obtained through BrioRx Specialty Pharmacy.

**1 PATIENT INFORMATION**

Last Name		First Name		Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #		
Allergies: <input type="checkbox"/> NKA or _____				
Street Address		City		
State	County	Zip Code		
Home Phone	Cell Phone			
Parent/Guardian	Day Telephone	Night Telephone		
Emergency Contact	Relationship	Telephone		

**2 PRESCRIBER INFORMATION**

Prescriber's Name	NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name
Street Address	City	
State	County	Zip Code
Contact Person at Office		Prescriber Specialty

**3**

**Department of Vermont Health Access  
PRIOR AUTHORIZATION REQUEST/PRESCRIPTION  
CYSTIC FIBROSIS INHALATION MEDICATION**

**Patient Diagnosis:**  Cystic Fibrosis  Other \_\_\_\_\_  
(Requires Review by DVHA Medical Director)

**Product:**

- Pulmozyme® (dornase alfa inhalation) 1 mg/ml 2.5 ml ampules
  - Administer via nebulizer once daily.  
Dispense # 30 Refill \_\_\_\_\_ times
  - Administer via nebulizer twice daily.  
Dispense # 60 Refill \_\_\_\_\_ times
- TOBI® (tobramycin) Podhaler 28 mg capsules (capsules for use with Podhaler only)
  - Administer 4 capsules via Podhaler twice daily, alternating 28 days on and 28 days off  
Dispense # 224 Refill \_\_\_\_\_ times
- TOBI® (tobramycin solution for inhalation) 300 mg/5 ml ampules
  - Administer via nebulizer twice daily, alternating 28 days on and 28 days off  
Dispense # 56 Refill \_\_\_\_\_ times

Deliver product to:  Patient's home  MD office  Clinic

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Fax Completed Form to:**

Fax Number: 800-218-3221

Phone Number: 866-843-3604



Goold Health Systems