



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

CYSTIC FIBROSIS MEDICATION

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

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		

PRESCRIBER'S 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				



Please Fax Completed form to:
Fax Number 1-800-218-3221
Phone Number 1-866-843-3604

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

Patient Diagnosis:

Cystic Fibrosis Other: _____
 (Requires Review by DVHA Medical Director)

Mucolytics:

- 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

Inhaled Antibiotics:

- 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
- TOBI® (tobramycin solution for inhalation) 300mg/5 ml ampules
Administer via nebulizer twice daily, Alternating 28 days on and 28 days off
- Tobramycin Solution for inhalation
Administer via nebulizer twice daily, alternating 28 days on and 28 days off
- Bethkis® (tobramycin) Solution
Administer via nebulizer twice daily, alternating 28 days on and 28 days off
- Kitabis® (tobramycin) Solution
Administer via nebulizer twice daily, alternating 28 days on and 28 days off
Dispense # _____ Refill _____ times (Maximum days' supply = 56 days)

CFTR Gene Mutation Potentiators:

- Kalydeco® (ivacaftor) packets, Ages 2-6
 - 50mg (less than 14kg) 75mg (greater than 14kg)
 - Take one packet by mouth every 12 hours with fatty food
- Kalydeco® (ivacaftor) 150mg tablets, Ages 6 and up
Take one tablet by mouth every 12 hours with fatty food
- Orkambi® (lumacaftor/ivacaftor) tablets
Take two tablets by mouth every 12 hours with fatty food
Dispense # _____ Refill _____ times (Maximum days' supply = 30 days)

Other: _____

Prescriber's Signature: _____ Date: _____