



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

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

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



Fax Completed Form to:
Fax Number: 800-218-3221
Phone Number: 866-843-3604

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

3 Department of Vermont Health Access PRIOR AUTHORIZATION REQUEST/PRESCRIPTION CYSTIC FIBROSIS INHALATION MEDICATION	
Patient Diagnosis: <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Other _____ (Requires Review by DVHA Medical Director)	
Product: <input type="checkbox"/> Pulmozyme® (dornase alfa inhalation) 1 mg/ml 2.5 ml ampules <input type="checkbox"/> Administer via nebulizer once daily. Dispense # 30 Refill ____ times <input type="checkbox"/> Administer via nebulizer twice daily. Dispense # 60 Refill ____ times <input type="checkbox"/> 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: <input type="checkbox"/> Patient's home <input type="checkbox"/> MD office <input type="checkbox"/> Clinic	
Prescriber's Signature: _____ Date: _____	

Last Updated 12/2011