



VERMONT
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 BrioVaRx Specialty Pharmacy.

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
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

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