

ST. JUDE

**SPECIALTY PHARMACY
& MEDICAL SUPPLIES**

CYSTIC FIBROSIS PRESCRIPTION FORM

121 St. Nicholas Ave Brooklyn, NY 11237

TEL: 718-381-5116 FAX: 718-417-3621

Proudly serving over 30 years

Today's Date

Anticipated Start Date

NEW PATIENT CURRENT PATIENT

Patient Name First Name _____ Middle Name _____ Last Name _____ DOB _____ Weight _____ Male Female
 Street Address _____ Apt # _____ City _____ State _____ Zip _____
 Daytime Tel _____ Evening Tel _____ Cell _____ Email _____
 Ship to Patient at Home Work **OR** Patient will pick up at Physician Office Pharmacy Date Needed _____
 ICD-9 Code 277.0 Cystic Fibrosis Blood Glucose test (if >14 y/o) _____ Most Recent PFT% _____ Allergies _____
 Other Conditions: Pancreatic Insufficiency CFRD Osteoporosis Liver Disease Depression Other _____
 Is *Pseudomonas aeruginosa* present in airway cultures? Yes No Concomitant Medications _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare Yes No If yes, Medicare# _____
 Prescription Card Yes No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____
 Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____
 Street Address _____ Suite # _____ City _____ State _____ Zip _____
 Tel _____ Fax _____ Email _____
 License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

- COLISTIMETHATE**
- COLISTIMETHATE KIT** *included as needed*
contains sterile water for injection,
syringes, needles and sharps container
- HYPER-SAL**® 7%
- KALYDECO** 150mg
SIG: Take 1 tab every 12 hours orally
- PULMOZYME**® 2.5mg
- TOBI**® 300mg *Pari LC Nebulizer tubing recommended*
1 tube per inhaled treatment Quantity: _____
Replace tubing every 6 months: Yes No
SIG _____
Quantity _____ Refill _____

NEBULIZER
 PARI LC PLUS® Use as directed with compressor.
 Replace tubing every 6 months (Manufacturer and CF Foundation recommendation)
 SIG _____ Quantity _____ Refill _____

PANCREATIC ENZYMES
CREON®
 Creon®5 Creon®10 Creon® 20
ZENPEP®
 Zenpep® 5 Zenpep® 10 Zenpep® 15 Zenpep® 20
PANCREAZE®
 Pancreaze® 4 Pancreaze® 10 Pancreaze® 16 Pancreaze® 20
 SIG _____ Quantity _____ Refill _____

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

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