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 Diesase ☐ 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**