Cystic Fibrosis Enrollment Form

Please fax the completed form to:

601-420-4040

2506 Lakeland Drive
Flowood, MS 39232
Phone: 866-420-4041
Fax: 601-420-4040
www.transcriptpharmacy.com

Delivery Need By: Delivery to: ☐Patients Home ☐Physician's Office ☐Other

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ☐Female ☐Male	Prescriber Name:
Address:	Address:
City, State, Zip: , ,	City, State, Zip: , ,
Phone:	Phone:
Date of Birth:	Fax:
Social Security Number:	DEA/NPI#:

INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis:	Has the patient been treated previously for this condition? ☐ Yes ☐ No
ICD-10 Code:	Medications failed:
Height: feet inches Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity:	Refills:
Bethkis	☐ 300mg/4ml	Administer one ampule twice daily (12 hours apart) by inhalation in alternating repeated cycles of 28 days on drug, followed by 28 days off drug	☐ 4 week supply	
Kitabis Pak	☐ 300mg/5ml	Administer one ampule twice daily (12 hours apart) by inhalation in alternating repeated cycles of 28 days on drug, followed by 28 days off drug	☐ 4 week supply	
Pulmozyme®	☐ 2.5mg	☐ Administer contents of one ampule once daily ☐ Administer contents of one ampule twice daily	☐ 30 Ampules ☐ 60 Ampules	
Tobramyacin	☐ 300mg/5ml	Administer one ampule twice daily (12 hours apart) by inhalation in alternating repeated cycles of 28 days on drug, followed by 28 days off drug	☐ 4 week supply	
Other:				

☐ Patient is interested in patient support programs

☐ Ancillary supplies provided for administration

Office Contact Name: _____ Preferred phone number & extension: _____

Physician Signature: _____ Date: _____

E-Scribe Rx and Fax this Form to 601-420-4040