Giant Eagle Specialty Pharmacy

Phone: 1-844-259-1891
Fax: 1-877-645-4142

To ePrescribe send prescription to:
Giant Eagle Pharmacy (#8991)
2500 Lovi Road
Freedom, PA 15042

CYSTIC FIBROSIS ENROLLMENT FORM

Today's Date: _____

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up **Date Shipment Needed:**_____ **Rx:** ☐ New ☐ Refill **RN Instruction Needed:** ☐ Yes ☐ No
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Date: _____ ☐ Male ☐ Female DOB: _____
Patient's First Name: _____ Patient's Last Name: _____
Address: _____ City: _____ State: ____ ZIP: _____
Best Phone #: _____ Alternate Phone #: _____
Weight: _____ Caregiver: _____ Allergies: _____
Store Preference (address): _____
TB/PPD Test Given? ☐ Yes ☐ No Negative TB Test & Date: _____
Emergency Contact Name:_____ Emergency Contact Phone #: _____

Insurance Information: Please fax copy of insurance card (front + back)

Clinical Information

Diagnosis/ICD-10 _____

- ☐ 277.00 CF without meconium ileus
- ☐ 277.01 CF with meconium ileus
- ☐ 277.02 CF with pulmonary manifestations
- ☐ 277.03 CF with GI manifestations
- ☐ 277.09 CF with other manifestations
- ☐ V83.81 CF gene carrier

- ☐ F508del
- ☐ G1244E
- ☐ G1349D
- ☐ G178R
- ☐ G551D
- ☐ G551S
- ☐ S1251N
- ☐ S1255P
- ☐ S549N
- ☐ S549R
- ☐ Other (please specify) _____

Other Conditions

- ☐ Pancreatic Insufficiency
- ☐ CFRD
- ☐ Osteoporosis
- ☐ Liver Disease
- ☐ Depression
- ☐ Other: _____

Prescription

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Pulmozyme®	☐ 2.5 mg ampule	☐ Inhale the contents of one ampule via nebulizer once daily ☐ Inhale the contents of one ampule via nebulizer twice daily	☐ 1 Box (30 ampules) ☐ 2 Boxes (60 ampules)	
☐ TOBI® (tobramycin inhaled solution)	☐ 300 mg ampule	☐ Inhale the contents of one ampule via nebulizer twice daily (every 12 hours) for 28 days on, followed by 28 days off	☐ 1 Box (56 ampules)	
☐ Tobi Podhaler	☐ 112 mg	☐ Inhale 112 mg (contents of four capsules) orally every 12 hours for 28 days on, followed by 28 days off	☐ 224 x 28	
☐ Other				

Prescriber Information

Date Prescription Needed: _____
Physician Name (please print): _____ Contact Name: _____
Phone #: _____ Fax #:_____ NPI #: _____
Office Address: _____ City: _____ State: _____ ZIP: _____
State License #: _____ DEA #: _____

In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below.

_____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: _____ **Date:** _____