Cystic Fibrosis
REFERRAL FORM

Phone: 818-390-9696 Toll-free: 855-265-7850 ● Fax: 818-804-3492 Toll-free fax: 855-450-6717 ● info@MedicoRX.com

Patient information		Prescriber information	
Name:	**DOB:**	**Prescriber's Name:**	
Address: **City, State, Zip**		**NPI#**	
		DEA#	**License#**
Phone #	**Alt#**	**Address** **City, State, Zip**	
SSN:			
Height:	**Wt:**	**Phone #**	**Fax #**
Allergies:			
Emergency Contact/ Phone #		**Contact Person:**	

Clinical Consideration

Diagnosis (ICD 10) : □ E84.0 Cystic fibrosis with pulmonary manifestations

□ E84.11 Meconium ileus in cystic fibrosis

□ E84.19 Cystic fibrosis with other intestinal manifestations

□ E84.8 Cystic fibrosis with other manifestations

□ E84.9 Cystic fibrosis, unspecified

□ Z14.1 Cystic fibrosis carrier

Other (please specify)_____

Other Conditions : □ Pancreatic Insufficiency □ CFRD □ Osteoporosis □ Liver Disease □ Depression
Blood Glucose Test (If > 14 yo) : _____(fasting) _____(non-fasting)
Most Recent PFT % : _____
Is Pseudomonas Aeruginosa present in airway culture? □ Yes □ No

Medication	Dose/Strength	Directions for Use	Quantity	Refills
□ **Bethkis®** (Tobramycin Inhalation Solution)	□ **2.5 mg**			
□ **Cayston®** (Aztreonam)				
□ **Hyper-Sal®** (NaCl Inhalation)	□ **7%**			
□ **Kalydeco®** (Ivacaftor)	□ **150 mg**			
□ **Kitabis® Pak** (Tobramycin Inhalation Solution)				
□ **Orkambi™** (Lumacaftor/Ivacaftor)				
□ **Pulmozyme®** (Dornase Alpha)				
□ **TOBI®** (Tobramycin)	□ **300 mg**			

PANCREATIC ENZYMES				
Medication	**Dose/Strength**	**Directions for Use**	**Quantity**	**Refills**
□ **Creon®** (Pancrelipase) □ **Pancreaze®** (Pancrelipase) □ **Zenpep®** (Pancrelipase)	□ **5** □ **10** □ **20** □ **5** □ **10** □**16** □**20** □ **5** □ **10** □**15** □**20**			
□ **Patient Requires Nebulizer**			□ **Replace Tubing Every 6 Months**	

By signing this form I authorize MedicoRX and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

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Prescriber's signature (no stamps) if brand required check this ☐ DAW___ **Date**