Pharmaceutical Specialties, LLC

A MAXOR COMPANY

Phone: 800-818-6486 ◆ Fax: 800-818-6490 ◆ www.psipharmacy.com

Demographics do not need to be completed if a demographic sheet is to follow

Diagnosis *(must be filled in with all relevant codes)*: ______________________________

Patient:______________________________ Wt:__________ DOB:__________ Last 4 digits of SSN:__________

Address:______________________________ City:______________________________ State:________ Zip:__________

Cell #:______________________________ Home #:______________________________ Gender: ☐ M ☐ F

To expedite the benefits investigation, please attach:

☐ ***Enlarged copy of the front and back of the insurance card*** ☐ ***Chart notes*** ☐ ***Labs*** ☐ ***Supporting clinical documentation***

Insurance:______________________________ ***Pharmacy Help Desk Phone:***____________________ ***ID Number:***____________________

Group Number:____________________ ***Rx Group:***____________________ ***Rx BIN:***____________________ ***Rx PCN:***____________________

☐ Rx: **Kalydeco** ☐ 150 mg Tablet (Take 1 tablet every 12 hours with fat-containing food) Refill:__________

☐ 50 mg Granules ☐ 75 mg Granules (Take 1 packet every 12 hours with fat-containing food) Refill:__________

☐ Rx: **Orkambi** ☐ 100/125 mg Tablets ☐ 200/125 mg Tablets (Take 2 tablets every 12 hours with fat-containing food) Refill:__________

☐ Rx: **Cayston® (75 mg) and Altera® Hand Held Device** Sig: Nebulize 1 vial TID **Disp 28 day supply with handset** Refill:__________

(Altera® Nebulizer System will be provided–System Includes Controller, 1 Altera ® Handset, Nebulizer Connection Cord, AC Power Supply, 4 AA Batteries).

☐ Rx: **Colistimethate 150 mg vials** Dispense all necessary supplies for preparation and administration. **Disp 30 day supply** Refill:__________

Sig: Swirl to mix and after dissolution, withdraw entire volume and nebulize BID ____ q other month ____ q month

☐ Mix vial with ____ mL of Sterile Water ☐ Mix vial with ____ mL each of Sterile Water and Normal Saline

☐ **LC® Sprint Nebulizer** ☐ **LC® Plus Nebulizer** ☐ **Compressor** Dispense 1 unit and replace nebulizer every 6 months.

☐ Rx: **Tobramycin 300 mg/5 mL ampules** Sig: Nebulize one ampule BID ___ q other month ___ q month **Disp 56 ampules (one box)** Refill:__________

☐ **LC® Plus Nebulizer/Pulmo-Aide Compressor** (Only FDA approved device combination) Dispense 1 unit and replace nebulizer every 6 months.

☐ Rx: **TOBI® 300 mg ampules** Sig: Nebulize one ampule BID ____ q other month ____ q month **Disp 56 ampules (one box)** Refill:__________

☐ **LC® Plus Nebulizer/Pulmo-Aide Compressor** (Only FDA approved device combination) Dispense 1 unit and replace nebulizer every 6 months.

☐ Rx: **Bethkis® 300 mg/4 mL ampules** Sig: Nebulize one ampule BID ____ q other month ____ q month **Disp 56 ampules (one box)** Refill:__________

☐ **LC® Plus Nebulizer/PARI Vios® PRO** Dispense 1 unit and replace nebulizer every 6 months.

☐ Rx: **Kitabis™ Pak 300 mg ampules** Sig: Nebulize one ampule BID ____ q other month ____ q month **Disp 56 ampules (one box)** Refill:__________

☐ **LC® Plus Nebulizer/Pulmo-Aide Compressor** (Only FDA approved device combination) Dispense 1 unit.

☐ Rx: **TOBI® Podhaler™** **Disp 28 day supply** Refill:__________

Sig: Inhale the contents of four 28 mg TOBI® Podhaler™ capsules BID using Podhaler™ device

☐ Rx: **Pulmozyme® Inhalation solution 2.5 mg** Sig: Nebulize ☐ Daily OR ☐ BID **Disp 30 day supply** Refill:__________

☐ **LC Plus® Nebulizer/PARI Vios®** ☐ **Sidestream®/Mobilaire™** ☐ **Sidestream®/Porta-Neb®** ☐ **Hudson T Up-Draft II®/Pulmo-Aide®**

☐ **Marquest Acorn II®/Pulmo-Aide®** (Only FDA approved device combinations) Dispense 1 unit with all necessary supplies & replace nebulizer every 6 months.

☐ Rx: **Hyper Sal® 7%** 4 mL (Box of 60) Sig: Nebulize BID before antibiotic therapy **Disp 30 day supply** Refill:__________

☐ Rx: **Hyper Sal® 3.5%** 4 mL (Box of 60) Sig: Nebulize BID before antibiotic therapy **Disp 30 day supply** Refill:__________

☐ Rx: **Creon®** ☐ **3,000** ☐ **6,000** ☐ **12,000** ☐ **24,000** ☐ **36,000** **Disp** ____________________ Refill:__________

Sig:______Capsules with meals ______Capsules with snacks ______Capsules with tube feeds

☐ Rx: **Zenpep®** ☐ **3,000** ☐ **5,000** ☐ **10,000** ☐ **15,000** ☐ **20,000** ☐ **25,000** **Disp** ____________________ Refill:__________

Sig:______Capsules with meals ______Capsules with snacks ______Capsules with tube feeds

☐ Rx: **Pertzye®** ☐ **8,000** ☐ **16,000** **Disp** ____________________ Refill:__________

Sig:______Capsules with meals ______Capsules with snacks ______Capsules with tube feeds

☐ Rx: **Other Enzyme:** ______________________________ **Disp** ____________________ Refill:__________

Sig:______Capsules with meals ______Capsules with snacks ______Capsules with tube feeds

☐ Rx: **Complete Formulation Vitamins**

☐ **Softgels** ☐ **Chewables** ☐ **Drops** ☐ **D3000** Sig:__________ ☐ **D5000** Sig:__________ **Disp 30 day supply** Refill:__________

☐ Rx: **Other Medication**:______________________________ Sig:__________ **Disp 30 day supply** Refill:__________

☐ Rx: **Other Medication**:______________________________ Sig:__________ **Disp 30 day supply** Refill:__________

Practice Name:______________________________

Provider Name:______________________________ **License #:**__________ **DEA #:**__________ **NPI #:**__________

Address:______________________________ **City:**____________________ **State:**________ **Zip:**__________

Office Contact:______________________________ **Phone:**__________ **Fax:**__________ **Email:**__________

PRESCRIBER SIGNATURE: ______________________________ **DATE:**__________