Medical Center
PHARMACY
Service Delivery Trust Since 1924

Cystic Fibrosis

Phone # 1-844-546-7577 • 619-263-1998
Fax # 1-844-240-2518 • 619-243-3245

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION

☐ Deliver Here

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: ☐ Male ☐ Female
Email : _____
Last 4# of SS: _____

PRESCRIBER INFORMATION

☐ Deliver Here

Name: _____
State License #: _____ NPI: _____
DEA #: _____ Tax ID _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

INSURANCE INFORMATION

If available, please fax copy of prescription insurance cards with this form (front and back).

PRESCRIPTION

Diagnosis/Clinical Information *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Diagnosis: _____

ICD-10: _____

☐ **Pulmozyme® (dornase alfa)** SIG:Dose: _____ mg for inhalation using recommended nebulizer

Frequency _____ Dispense Quantity: _____ Re~lls:_____

NKDA Known Drug Allergies_____

☐ **Tobi® (tobramycin)** SIG:Dose: _____ mg for inhalation using recommended nebulizer

Frequency _____ Dispense Quantity: _____ Re~lls:_____

NKDA Known Drug Allergies _____

Deliver to: Physician Office_____ Patient Home _____

PATIENT SUPPORT PROGRAMS: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Physician Signature: **Date:**

Dispense as written	**Date**	**Substitution Premissable**	**Date**

# of Prescriptions:_____

There are 1 of 4 options for you when finding our company: 1. NPI # - 1821395609, 2. NCPDP # - 5640289
3. Company Name: Community Medical Center Pharmacy, 4. Company Address: 610 Gateway Center Way, San Diego, CA 92102