



**Prescription Order Form**  
**Fax to (877) 291-1155**

Toll Free Phone 877-291-1122 ~ Toll Free Fax 877-291-1155  
 4010 Wedgeway Court ~ Earth City, MO ~ 63045

Name \_\_\_\_\_  Male  Female Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Allergies \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**Please Attach a Copy of Insurance Card(s)**

Diagnosis / ICD9 Code

Gene Mutation

277.02 CF w/Pul Manif.  
 494.0 Bronch. w/o AC Exac  
 496 Chr. Airway Obstr. NEC

G551D  
 Other \_\_\_\_\_

**Equipment:**  Trio® Nebulizer  PARI LC® Plus Nebulizer  Other \_\_\_\_\_

Other \_\_\_\_\_

Medications	Dosage	Directions	Qty	Refill
Albuterol	<input type="checkbox"/> 2.5mg/3ml <input type="checkbox"/> 2.5mg/0.5ml <input type="checkbox"/> 1.25mg/3ml	QD BID Other _____		
Amikacin	<input type="checkbox"/> 500mg/4ml <input type="checkbox"/> 250mg/4ml <input type="checkbox"/> 125mg/2ml	BID Other _____		
Cayston® with Altera® Nebulizer	<input type="checkbox"/> 75mg	TID	28 Days/ Monthly or Every Other Month	
Colistimethate	<input type="checkbox"/> 75mg <input type="checkbox"/> 150mg <input type="checkbox"/> Premixed <input type="checkbox"/> Powder with: sterile water or sodium chloride	BID Other _____	QTY _____ Monthly or Every Other Month	
Creon®	<input type="checkbox"/> 6,000 USP lipase units <input type="checkbox"/> 12,000 USP lipase units <input type="checkbox"/> 24,000 USP lipase units	Sig:		
Hyper-Sal™	<input type="checkbox"/> 7% / 4ml Hypertonic Saline <input type="checkbox"/> _____% _____ml	QD BID Other _____		
<b>Kalydeco (ivacaftor)</b>	<input type="checkbox"/> 150mg with fat-containing food	Q12H Other _____	<b>60</b>	
Pulmozyme®		QD BID Other _____		
Replesta	<input type="checkbox"/> 50,000 IU	Sig:		
Singular	<input type="checkbox"/> 4mg <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg	Sig:		
Tobramycin	<input type="checkbox"/> 150mg/3ml <input type="checkbox"/> 170mg/3.4ml	BID Other _____	QTY _____ Monthly or Every Other Month	
TOBI®	<input type="checkbox"/> 300mg/5ml	BID Other _____	28 Days/ Monthly or Every Other Month	
Vancomycin	<input type="checkbox"/> 125mg/4ml <input type="checkbox"/> 250mg/4ml	BID Other _____		
Xopenex®	<input type="checkbox"/> 0.63mg <input type="checkbox"/> 1.25mg <input type="checkbox"/> HFA	QD BID Other _____		
ZENPEP™	<input type="checkbox"/> 5,000 USP lipase units <input type="checkbox"/> 10,000 USP lipase units <input type="checkbox"/> 15,000 USP lipase units <input type="checkbox"/> 20,000 USP lipase units	Sig:		
Zithromax	<input type="checkbox"/> 250mg <input type="checkbox"/> 500mg	Sig:		
Other				

**Prescribing Physician Information:**

Physician Signature \_\_\_\_\_ / \_\_\_\_\_ Date \_\_\_\_\_  
(Substitutions Permitted) (Dispense as Written)

Physician Name \_\_\_\_\_ Practice/Facility Name \_\_\_\_\_ Physician Specialty \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email Address \_\_\_\_\_

DEA # \_\_\_\_\_ NPI # \_\_\_\_\_ License # \_\_\_\_\_

Name of Contact Person \_\_\_\_\_ Contact Person #, ext or email \_\_\_\_\_