

CYSTIC FIBROSIS REFERRAL FORM

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Patient Information

Patient Name: _____ DOB: _____ Sex: M F
 Phone: _____ Cell Phone: _____ Email Address: _____
 Address: _____ City: _____ State: _____ Zip: _____
 ICD-10 Diagnosis Code: _____ Diagnosis: _____
 Allergies (please note reaction): _____ Latex
 Current Medications: (list here or attach a medication list): _____
 Comorbidities: (list here or attach a list): _____

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Tobi (tobramycin)	<input type="checkbox"/> 300mg/5mL Nebulizer Solution	Inhale 300mg via nebulizer every 12 hours. Administer in repeated cycles of 28 days on followed by 28 days off drug.	56-day supply	
	<input type="checkbox"/> 28mg/capsule Podhaler	Inhale the contents of 4 capsules (112mg total) every 12 hours. Administer in repeated cycles of 28 days on followed by 28 days off drug.	56-day supply	
Other Medication Name:				

Treatment History: New to Therapy Continuation of Therapy

Prescriber Information

Prescriber Name: _____
 State License #: _____ DEA #: _____ NPI: _____
 Additional Contact Person Name: _____
 Group or Hospital: _____ Phone: _____
 Fax: _____ Email Address: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Prescriber Signature: _____

Product Substitution Permitted _____ Date _____ Dispensed as Written _____ Date _____

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

Ship to Patient Ship to Prescriber/Clinic Pick up at Albertsons Companies Pharmacy

Date Medication Needed: _____

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It's as simple as caring.

Ph. 800-834-8778
 Fax 877-466-8040

E-Scribe Information:
 Albertsons/Safeway Pharmacy • 12874 E. Florence Ave.
 Santa Fe Springs, CA 90670 • NCPDP 5617418 • NPI 1164451100