CYSTIC FIBROSIS REFERRAL FORM

www.albertsons.com/specialtycare • Phone: 877.466.8028 • Fax: 877.466.8040

Albertsons Companies Specialty Care

Jewel Osco · Albertsons · SAFEWAY · VONS · ACME · shaw's · star market · PAVILIONS · CARRS · Randalls · Tom Thumb

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
☐ Tobi (tobramycin)	☐ 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	
	☐ 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: _____