CYSTIC FIBROSIS

Referral Phone: 800-622-9321
Referral Fax: 614-367-1684

DECILLION HEALTHCARE

Demographics

Last Name:	First Name:	Circle one: M F	D.O.B.
Home Address:	City:	State:	Zip:
Height:	Weight:	Allergies:	

Preferred Method of Contact: ☐ Email ☐ Phone (Home): Phone (Cell): Phone (Work):

Email: ____ Last 4 of SSN #: ______________________ Primary Language ____________________

Insurance

Primary Insurance: *Complete and Attach Copies of card	City:	State:	Phone:
Card Holder Name:	ID #:	Group #:	

Employer:	Prescription Card:	City:	State:	Phone:

Medical Necessity

Statement of Medical Necessity Date of Diagnosis:
Diagnosis: ☐ 277.0 Cystic Fibrosis ☐ ____________________ ☐ ____________________ ☐ ______________________ ☐ ____________________

Pertinent Medical History/Other Conditions:
Other Conditions: ☐ Pancreatic Insufficiency ☐ CFRD ☐ Osteoporosis ☐ Liver Disease ☐ Depression ☐ Pregnancy (due date) _________ ☐ Other_________
Blood Glueose test result (if > 14 y/o): _____________________ ☐ Fasting ☐ Non-Fasting
Most Recent PFT%: ____________________________ Is Pseudomonas aeruginosa present in airway cultures? ☐ Yes ☐ No
Concomitant Medications:____

Prescription

Medication	Strength	Directions	Qty	Refills
☐ Colistimethate ®				
☐ Colistimethate Kit - This complimentary kit (contains sterile water for injection, syringes, needles & sharps container) will be included as needed with dispensing.				
☐ Hyper-Sal ®	7%			
☐ Pulmozyme ®	2.5 mg			
☐ TOBI ®	300 mg			
***Pari LC nebuliser: tubing recommended one tube per inhaled treatment		Replace tubing every 6 months?		
☐ Kalydeco ®	150 mg	Take tab every 12 hours orally		
Nebulizers				
☐ Pari LC Plus ®		Use as directed with compressor		
☐ Replace tubing every 6 months (Manufacturing and CF Foundation recommendation				
Pancreatite Enzymes				
☐ Creon ®	☐ Creon 5 ☐ Creon 10 ☐ Creon 20			
☐ Pancreaze ®	☐ Pancreaze 4 ☐ Pancreaze 10 ☐ Pancreaze 16 ☐ Pancreaze 20			
☐ Zenpep ® (pancrelipase)	☐ Zenpep 5 ☐ Zenpep 10 ☐ Zenpep 15 ☐ Zenpep 20			

Physician

MD:	License:	DEA #:	NPI #:
Specialty:	Practice:	Email:	Hospital/Clinic:
Phys. Phone:	Phys. Fax:	Address:	Office Contact:

Date Shipment Needed: ____________ Ship To: ☐Patient ☐Physician; ☐Other________________________ All the supplies including syringes and needles will be dispensed if requested above.

☐ Patient is interested in support programs

Physician Signature: ____ Per state law must write out DAW (if applicable): ______________________ Date: _________________

By signing below, I authorize Streamline DBA Decillion Healthcare ("Streamline DBA Decillion Healthcare") to: Collect my health condition and prescription information from my doctor, healthcare provider, health insurer or pharmacist in order to ensure its accuracy and completeness and to communicate to the patient support program of the pharmaceutical manufacturer (the "Program"); and contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and patient assistance programs on my behalf to determine if I am eligible for assistance. I hereby authorize my doctor, healthcare provider, health insurer or pharmacist to provide my health condition and prescription information to Streamline DBA Decillion Healthcare and to the Program. I understand that I may revoke this authorization at anytime by sending a letter to Streamline DBA Decillion Healthcare.

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