CureStat Rx
Home Infusion and Specialty Pharmacy

CYSTIC FIBROSIS ANTIBIOTICS & MUCOLYTICS

Phone: (888)963-6544 Fax: (858)281-0045

PATIENT INFORMATION ☐ Deliver Here

Patient Name: _____
DOB: _____ Gender: ☐ Male ☐ Female
Address: _____
City_____ State_____ Zip: _____
Primary Phone: _____ SSN: _____
Caregiver Name: _____
Alternate Phone: _____

PRESCRIBER INFORMATION ☐ Deliver Here

Prescriber Name: _____
State License #: _____ DEA #: _____
NPI #: _____
Address: _____
City_____ State_____ Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

Please fax a copy of front and back of the insurance card(s).

Clinical Information (Please fax pertinent lab information)

Diagnosis: ☐ E84.0 (pulmonary manifestations) ☐ E84.11 (meconium ileus) ☐ E84.19 (gastrointestinal manifestations) ☐ E84.8 (other manifestations) ☐ E84.9 (unspecified)

Mutations: _____

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of therapy	Start date	End Date

Allergies: ☐ NKDA ☐ Other: _____

Comorbidities: _____

Concomitant Medications: _____

Drug	Dose/Strength	Directions	Qty	Refills
INHALED ANTIBIOTICS				
☐ **BETHKIS** (tobramycin inhalation solution)	☐ 300mg Ampule	☐ Inhale 300 mg (contents of one ampule) orally every 12 hours via nebulizer for 28 days on, followed by 28 days off		
☐ **KITABIS PAK** (tobramycin inhalation solution)	☐ 300mg/5mL Ampule	☐ Inhale 300 mg (contents of one ampule) orally every 12 hours via nebulizer for 28 days on, followed by 28 days off		
☐ **TOBI** (tobramycin solution)	☐ 300mg Ampule	☐ Inhale 300 mg (contents of one ampule) orally every 12 hours via nebulizer for 28 days on, followed by 28 days off		
☐ **TOBI PODHALER** (tobramycin inhalation powder)	☐ 28mg Capsule	☐ Inhale 112 mg (contents of four capsules) orally every 12 hours for 28 days followed by 28 days off		
☐ **Other:** _____	☐ Other: _____	☐ Other: _____		
MUCOLYTICS				
☐ **PULMOZYME** (dornase alfa)	☐ 2.5 mg/2.5 mL Ampule	☐ Inhale 2.5 mg (contents of one ampule) orally once daily via nebulizer		
☐ **HYPERTONIC SALINE** (sodium chloride)	☐ 3% Solution ☐ 3.5% Solution ☐ 7% Solution	☐ Inhale the contents of one vial orally _____ times per day via nebulizer		

☐ Product substitution permitted ☐ Dispense as written

Prescriber's Signature: _____ Date: _____