IVSOLUTIONS
RESPIRATORY SERVICES • HOME INFUSION • SPECIALTY PRODUCTS

Phone: 1-800-658-6046 • Toll Free Fax: 800-791-7851
E-mail: ivsolutions@maxor.com • www.ivsolutions.com

CF Enrollment Form

PATIENT INFORMATION

Patient Name_____ ☐Male ☐Female

Date of Birth_____ ☐English ☐Spanish ☐Other_____

Address_____ Apt #_____

City_____ State_____ Zip_____

Phone # - Primary_____ Secondary_____

Please attach copy of insurance information or copy of insurance cards (both sides).

NEBULIZERS / COMPRESSORS/SYSTEMS / MASKS

NEBULIZERS	COMPRESSORS/SYSTEMS	MASKS
☐Pari LC® Sprint	☐Altera System	☐Pari Smartmask Baby
☐Pari LC® PLUS	☐eRapid System	☐Pari Smartmask Kids
☐Pari LC® Star	☐Trio System	☐Pari Baby Size #2
☐Sidestream Plus	☐Pari Vios Pro	☐Pari Baby Size #3
☐Trio™	☐Pari Trek 5	☐Pari Bubbles the Fish
☐eRapid®	☐PulmoAide	☐Pari Adult Mask
☐Altera	☐_____	☐_____

PHYSICIAN INFORMATION

Physician Name_____ NPI_____

Office Contact Name_____

Address_____ City/StateZip_____

Phone _____ Fax _____

By signing this form, I authorize IV Solutions to act as my agent for Prior Authorizations & Prescription Reimbursement for the listed patient.

Physician Signature_____ Date_____

****For Ohio patients, please only choose one (1) prescription per form****

DIAGNOSIS

☐E84.0 - CF w/ pulmonary manifestations
☐E84.8 - CF w/ other manifestations
☐E84.19 - CF w/ intestinal manifestations
☐B96.5 - Pseudomonas
☐J47.9 - Bronchiectasis
☐Other:_____

AIRWAY CLEARANCE & DEVICES

☐Acapella Choice ☐Aerobika ☐Vortex Holding Chamber ☐Toddler ☐Child ☐Adult

INHALED ANTIBIOTICS

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
Bethkis	☐ 300 mg/4ml	Nebulize 1 vial twice daily		
Cayston® & Altera®	☐ 75mg	Nebulize 1 vial 3 times daily via *Altera Nebulizer*		
Colistimethate 150mg	☐ 75 mg (*Trio Nebulizer)* ☐ 150 mg	Mix with 6ml of Sterile Water, Nebulize 3ml twice daily Mix with 3ml of Sterile Water, Nebulize 3ml twice daily		
Kitabis Pak	☐ 300 mg/5ml	Nebulize 1 vial twice daily		
TOBI®	☐ 300 mg/5ml	Nebulize 1 vial twice daily		
TOBI Podhaler®	☐ 28 mg Capsule	Inhale 4 capsules twice daily via *Podhaler*		
Tobramycin (generic)	☐ 300mg/5ml	Nebulize 1 vial twice daily		
Tobramycin (compound)	☐ 150mg/3ml	Nebulize 1 vial twice daily		

☐28 days on 28 days off
☐Continuous
☐DAW_____
☐Other_____

INHALED MUCOLYTIC/EXPECTORANT

Hypertonic Saline	☐ 3% ☐3.5% ☐7% ☐10% ☐DAW (Hyper-Sal or PulmoSal 7%)	Nebulize 4ml or____ ml twice daily or_____ as directed		
Pulmozyme	☐ 2.5 mg	Nebulize one (1) vial ☐once daily ☐twice daily		

INHALED BRONCHODILATORS

Albuterol	☐ 0.042% ☐ 0.083% ☐ Proair ☐ Ventolin	Nebulize 1 vial _____ time(s) daily or every ___hours Inhale ____puff(s) every _____hours or ____times daily		
Xopenex	☐ 0.31mg ☐ 0.63mg ☐1.25mg ☐ HFA 15 gm	Nebulize 1 vial _____ time(s) daily or every ___hours Inhale ____puff(s) every _____hours or ____times daily		

ENZYMES

Creon	☐ 3,000 ☐ 6,000 ☐ 12,000 ☐ 24,000 ☐ 36,000	___with meals___with snacks. Max per day____QTY_____Refills:___
Pancreaze	☐ 4,200 ☐ 10,500 ☐ 16,800 ☐ 21,000	___with meals___with snacks. Max per day____QTY_____Refills:___
Pertzye	☐ 8,000 ☐ 16,000	___with meals___with snacks. Max per day____QTY_____Refills:___
Ultresa	☐ 13,800 ☐ 20,700 ☐ 23,000	___with meals___with snacks. Max per day____QTY_____Refills:___
Zenpep	☐ 3,000 ☐ 5,000 ☐ 10,000 ☐ 15,000 ☐ 20,000 ☐ 25,000 ☐ 40,000	___with meals___with snacks. Max per day____QTY_____Refills:___
Viokace	☐ 10,440 ☐ 20,880	___with meals___with snacks. Max per day____QTY_____Refills:___

VITAMINS

AquADEKS ☐Softgel ☐Chewable ☐Liquid
Choiceful ☐ Softgel ☐ Chewable
MVW Complete ☐ Softgel ☐ Chewable

SIG:_____
_____
QTY_____Refills____

ANTIBIOTICS

Azithromycin ☐250mg ☐500mg ☐Susp_____
Sig:_____QTY_____Refills_____
Bactrim ☐DS ☐ Susp_____
Sig:_____QTY_____Refills_____
Cipro ☐500mg ☐750mg
Sig:_____QTY_____Refills_____

OTHER:

Revised: 2/2016