

Patient Information		Prescriber + Shipping Information	
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____ Please fax a copy of front and back of the insurance card(s).		Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never	
Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis: <input type="checkbox"/> E84.0 (pulmonary manifestations) <input type="checkbox"/> E84.11 (meconium ileus) <input type="checkbox"/> E84.19 (gastrointestinal manifestations) <input type="checkbox"/> E84.8 (other manifestations) <input type="checkbox"/> E84.9 (unspecified)			
Mutations: <input type="checkbox"/> F508del <input type="checkbox"/> G1244E <input type="checkbox"/> G1349D <input type="checkbox"/> G178R <input type="checkbox"/> G551D <input type="checkbox"/> G551S <input type="checkbox"/> R117H <input type="checkbox"/> S1251N <input type="checkbox"/> S549N <input type="checkbox"/> S549R <input type="checkbox"/> S1255P <input type="checkbox"/> Other _____			
Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____	Reason for Discontinuation of Therapy _____ _____	Approximate Start Date _____ _____	Approximate End Date _____ _____
Comorbidities: _____ Concomitant Medications: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			
Prescription	Directions	Dosage/Quantity	Refill
<input type="checkbox"/> Aquadeks			_____
<input type="checkbox"/> Multivitamins			_____
<input type="checkbox"/> Creon®	Take listed number of capsules per meal/snack whole or sprinkled capsule(s) on a small amount of acidic soft food immediately by mouth with water, juice, or other liquid. Do not mix directly into infant formula or breast milk. Do not crush or chew capsule shell or contents. Breakfast: _____ capsules Lunch: _____ capsules Dinner: _____ capsules Snacks: _____ capsules	<input type="checkbox"/> _____ x 6,000 lipase unit capsules <input type="checkbox"/> _____ x 12,000 lipase unit capsules <input type="checkbox"/> _____ x 24,000 lipase unit capsules <input type="checkbox"/> _____ x 36,000 lipase unit capsules	_____
<input type="checkbox"/> Pancreaze®		<input type="checkbox"/> _____ x 16,800 lipase unit capsules <input type="checkbox"/> _____ x 21,000 lipase unit capsules	_____
<input type="checkbox"/> Pertzeye®		<input type="checkbox"/> _____ x 8,000 lipase unit capsules <input type="checkbox"/> _____ x 16,000 lipase unit capsules	_____
<input type="checkbox"/> Zenpep®		<input type="checkbox"/> _____ x 10,000 lipase unit capsules <input type="checkbox"/> _____ x 15,000 lipase unit capsules <input type="checkbox"/> _____ x 20,000 lipase unit capsules <input type="checkbox"/> _____ x 25,000 lipase unit capsules <input type="checkbox"/> _____ x 40,000 lipase unit capsules	_____
Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____			
<i>Stamp signature not allowed, physician signature required.</i>			
Prescriber's Signature: _____			Date: _____
I authorize Diplomat Pharmacy, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc.			

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