Kitabis Connect™

Service Request and Prescriptions

Fax 1-844-288-7308 Phone 1-855-334-6730 Email kitabisconnect@rxallcare.com

PARI

1. Patient Information (Please complete all fields to prevent any delays)

First Name | Last Name | SS# (Last four only)

☐ Male ☐ Female

Sex | Date of Birth (MM/DD/YYYY)

Address

City | State | Zip

Cell Phone | Home Phone | E-mail Address

Caregiver/Guardian | Relationship | Caregiver/Guardian Phone

2. Insurance Information (Attach copy of insurance card-front & back)

Primary Insurance | Phone #

Insurance ID # | Group # | BIN # | PCN #

Subscriber's Name (if not self) | Employer

Secondary Insurance | Phone #

Insurance ID # | Group # | BIN # | PCN #

Subscriber's Name (if not self) | Employer

3. Patient Signs Consent and HIPAA Authorization

I authorize my health plans, physicians, health care professional, hospital, clinic, pharmacy or other health care provider to disclose my personal health information, including information relating to my medical condition, treatment, care management and health insurance, as well as all information provided on this form and any prescription ("Personal Health Information"), to PARI, its affiliates and their representatives, agents and contractors for the following purposes, including investigating insurance coverage, fulfilling and coordinating delivery, assisting with product training, providing product support, providing patient support, and any internal use by PARI. I understand that my information disclosed under this authorization may be re-disclosed by PARI and no longer protected by federal or state privacy laws. I understand that I may refuse to sign this authorization, and my treating providers and health plans may not condition current or future treatment, payment or eligibility for benefits on my provision of this authorization. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at anytime by mailing a letter requesting such cancellation to PARI, 2412 PARI Way, Midlothian, VA 23112, but that this cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization expires five (5) years from the date signed below or as dictated by applicable state law.

I understand that my pharmacy providers may receive remuneration for disclosing my Personal Health Information pursuant to this Authorization. I further authorize my pharmacy providers to use my Personal Health Information to communicate with me about the drug that has been prescribed for me and understand that they may receive a fee for such communications.

X _____ / / _____

Patient/Legal Guardian Signature | **Date of Signature (MM/DD/YYYY)**

4. Prescriber Information

First Name | Last Name | Practice Name

Office Contact Name | Phone | Fax

Address

City | State | Zip

State Medical License # | NPI #

Medicaid Provider # | Medicare Provider #

5. Clinical Information

☐ **E84.9 Cystic Fibrosis, unspecified** ☐ **E84.0 Cystic Fibrosis with pulmonary manifestations** ☐ **B96.5 Pseudomonas aeruginosa**

Previous Therapies: _____

Please submit clinical documentation and chart notes with this form to assist in the completion of a prior authorization for your patient if required by their insurance.

6. Complete Prescription and Statement of Medical Necessity

☐ **Kitabis® Pak** (Tobramycin Inhalation Solution) ☐ **PulmoAide® 5650D Compressor*** *Commercial Insurance Patients Only

☐ **SIG: Dose:** 300 mg in a single-use 5 mL ampule twice daily

Quantity: 56 ampules **Refills:** 2 ☐ 4 ☐ 6 ☐

☐ **Other SIG:** _____

Specialty Pharmacy Network: Kitabis® Pak is available through a limited specialty pharmacy network.

☐ Walgreens Specialty Pharmacy ☐ Skywalk Pharmacy ☐ Pharmaceutical Specialty Inc.

☐ Kroger Specialty Pharmacy ☐ IV Solutions ☐ Intermountain Specialty Pharmacy

☐ Foundation Care Pharmacy ☐ Freedom Pharmacy/CF Pharmacy ☐ Diplomat Pharmacy

☐ CVS Caremark Specialty ☐ Cigna Specialty Pharmacy Services ☐ Briova Rx

☐ Accredo ☐ Other: _____

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by PARI and it's employees or agents to assist in obtaining coverage for Kitabis® Pak and to assist in initiating or continuing Kitabis® Pak therapy. I appoint PARI, on my behalf, to convey this prescription to the dispensing pharmacy.

X _____ / / _____

Prescriber's Signature | **Date of Signature (MM/DD/YYYY)**