Respiratory Medication Prescription

Referring Company _____

PATIENT INFORMATION

Patient Name _____
Address _____
City, State Zip _____
Home Phone _____
Emergency Phone _____
Date of Birth _____ Gender _____
Social Security # _____

PHYSICIAN INFORMATION

Physician Name _____
Address _____
City, State Zip _____
Phone _____
Fax _____
UPIN / NPI _____ / _____
Nurse/Contact Person _____

INSURANCE INFORMATION

Name of Insured _____

Primary: _____ Policy# _____ Group# _____ Phone _____

Secondary: _____ Policy# _____ Group# _____ Phone _____

DIAGNOSIS ICD-10:

____ J44.9 (COPD) ____ J45.998 (Asthma) ____ J42 (Chronic Bronchitis) ____ J43.9 (Emphysema) ____ J47.9 (Bronchiectasis) ____ Other_____

MEDICATION (Please Check Prescribed Meds)	**FREQUENCY/DIRECTIONS** (Please Check Frequency of Dosage)
☐ Gen. DuoNeb (Ipr 0.02% 0.5mg/Alb 0.083% 2.5mg/3.0ml)	___QID(#120) four daily ___TID(#90) three daily ___BID(#60) twice daily ___AND PRN_____
☐ Albuterol 0.083% 2.5mg/3.0ml	___QID(#120) four daily ___TID(#90) three daily ___BID(#60) twice daily ___AND PRN_____
☐ Ipratropium 0.02% 0.5mg/2.5ml	___QID(#120) four daily ___TID(#90) three daily ___BID(#60) twice daily ___AND PRN _____
☐ Budesonide 0.25mg/2ml	___BID(#60) twice daily ___QD(#30) once daily
☐ Budesonide 0.5mg/2ml	___BID(#60) twice daily ___QD(#30) once daily
☐ Perforomist 20mcg/2ml	___BID(#60) twice daily ___QD(#30) once daily
☐ Brovana 15mcg/2ml	___BID(#60) twice daily ___QD(#30) once daily
☐ **YUPELRI 175mcg/3ml Inh. Soln**	**___QD once daily (30vials, 30day supply)**
☐ **Tobramycin 300mg/5ml Inh.Soln.**	**___BID twice daily (56 vials, 28 day supply)**
☐ Other: _____	Directions: _____

Order Good for TWELVE MONTHS, Unless Otherwise Noted.

Start Date: _____

➔ **Refills**: _____ **Please circle one:** 12 months 6 months 3 months **Other:**_____

➔ **Circle Quantity -** 90 days 30 days

☐ **Length of need 99 months (99= lifetime)**

Nebulizer Administration Supplies
(Please check prescribed supplies)

- ☐ **E0570 Nebulizer (Compressor)**
- ☐ **A7003 Disposable Neb Kit (2/mo)**
- ☐ **A7004 Disp. Neb Cups (2/mo)**
- ☐ **A7005 Reusable Neb Kit (1/6mo)**
- ☐ **A7015 Nebulizer Mask (1/mo)**
- ☐ **A7525 Neb Trach Mask (1/mo)**
- ☐ **A7013 Compressor Filters (2/mo)**

I certify that I am the treating physician/HCP identified on this form. I have reviewed and completed the sections of this Prescription/ Detailed Written Order (DWO). Any statement on my letterhead, attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

MD/DO/NP/PA Signature (Required)

X _____ _____ _____

Product Selection Permitted *Date* *Dispense as written*

Fax this form along with Patient Demographics to: 800-638-0294