Respiratory Medication Prescription

Cost Center # _____

Office name _____ Office contact name _____ **ORDER DATE** _____

Prescriber's State License _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip_____

PATIENT INFORMATION

Patient name _____ DOB_____
Last First

Address _____ Home phone _____

City _____ State _____ Zip_____ Mobile phone _____

Email _____ Known Allergies _____

Insurance co: _____

ID/MBI #_____

Group #_____

Diagnosis ICD-10: A specific ICD-10 code(s) must be provided either on the line below or in the patient's chart notes. Please check off the appropriate qualifying diagnosis code(s), or write in the code(s) under "Other."

DIAGNOSIS CODES: ☐ J44.9 – Chronic Obstructive Pulmonary Disease ☐ J43.9 – Emphysema ☐ J47.9 – Bronchiectasis
☐ J45.998 – Asthma ☐ J45.909 – Asthma, Unspecified ☐ J42 – Chronic Bronchitis ☐ Other_____

MEDICATIONS AND DIRECTIONS FOR USE	FREQUENCY: Once Daily	BID	TID	QID	Q4H	Other
SABA (Short-Acting Beta$_2$ Agonist):						
☐ Albuterol Sulfate 0.083% inhalation solution 2.5mg/3mL	☐	☐	☐	☐	☐	_____
Directions for use:* _____						
Short-Acting Anticholinergic:						
☐ Ipratropium Bromide 0.02% inhalation solution 0.5mg/2.5mL	☐	☐	☐	☐	☐	_____
Directions for use:* _____						
Combo (SABA + Short-Acting Anticholinergic):						
☐ **Albuterol** 2.5mg **with Ipratropium** 0.5mg in 3mL normal saline (generic of DuoNeb®)	☐	☐	☐	☐	☐	_____
Directions for use:* _____						
LABA (Long-Acting Beta$_2$ Agonist):						
☐ Brovana® (arformoterol tartrate) 15mcg/2mL	☐	☐	N/A	N/A	N/A	_____
Directions for use:* _____						
☐ Perforomist® (formoterol fumarate) 20mcg/2mL	☐	☐	N/A	N/A	N/A	_____
Directions for use:* _____						
Long-Acting Anticholinergic:						
☐ Yupelri® (revefenacin) inhalation solution 175mcg/3mL	☐	N/A	N/A	N/A	N/A	_____
Directions for use:* _____						
Corticosteroid:						
☐ Budesonide 0.25mg/2mL	☐	☐	N/A	N/A	N/A	_____
Directions for use:* _____						
☐ Budesonide 0.5mg/2mL	☐	☐	N/A	N/A	N/A	_____
Directions for use:* _____						
Aminoglycoside Antibiotic:						
☐ Tobramycin Inhalation Solution 300mg/5mL	☐	☐	N/A	N/A	N/A	_____
Directions for use:* _____						
Phosphodiesterase-4 Inhibitor (PDE4):						
☐ Daliresp® (roflumilast) 500mcg tablet	☐	☐	N/A	N/A	N/A	_____
Directions for use:* _____						
☐ **Other (please specify):** _____ **Directions for use:*** _____						

***NOTE: Medicare does not reimburse for PRN (as needed) orders without an accompanying frequency.**

LON: 12 months unless otherwise noted: _____

30 day supply provided unless otherwise specified: _____

Total number of prescribed items** _____

**Please refer to your state-specific guidelines regarding the number of drugs that may be prescribed per form.

EQUIPMENT AND OXIMETRY TESTING

LON: 99 months unless otherwise noted: _____

☐ E0570 Nebulizer with air compressor
☐ A7003 Nebulizer admin set, disposable (2 x 1 mo)
☐ A7004 Nebulizer, disposable (2 x 1 mo)
☐ A7005 Admin set, non-disposable (1 x 6 mo)
☐ A7013 Filter, disposable (2 x 1 mo)
☐ A7015 Aerosol mask (1 x 1 mo)
☐ A7525 Tracheostomy mask (1 x 1 mo)
☐ Overnight oximetry testing
☐ Other _____

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the items prescribed.

☐ **Do not substitute — Dispense as written**

Print prescriber's name _____ **Prescriber email** _____ **NPI #** _____

Prescriber's signature _____ **Date** _____

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