

Respiratory Enrollment Form

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION

(Complete the following and include demographic sheet)

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 DOB: _____ Male Female
 Primary Phone: _____
 Alternate Phone: _____
 Primary Language: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
 State License #: _____ NPI #: _____
 DEA #: _____
 Address: _____
 City, St, Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____ Phone: _____

INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

DIAGNOSIS / CLINICAL INFORMATION

- | | |
|---|---|
| <input type="checkbox"/> J44.9 Simple Chronic Bronchitis
<input type="checkbox"/> J44.9 Obstructive chronic bronchitis without exacerbation
<input type="checkbox"/> J44.9 Chronic airway obstruction, not elsewhere classified
<input type="checkbox"/> J44.0 With acute bronchitis
<input type="checkbox"/> J44.1 With (acute) exacerbation
<input type="checkbox"/> Other _____ | <input type="checkbox"/> J41.1 Mucopurulent chronic bronchitis
<input type="checkbox"/> J43.9 Other emphysematous
<input type="checkbox"/> R23.8 Emphysematous bleb |
|---|---|

PRESCRIPTION INFORMATION Nebulized Medications

MEDICATION	DOSE/STRENGTH	DIRECTIONS
<input type="checkbox"/> Yupelri (revefenacin inhalation solution)	175mcg / 3mL vial	BID
<input type="checkbox"/> Perforomist® (formoterol fumarate inhalation solution)	20mcg / 2mL vial	QD
<input type="checkbox"/> Brovana®	15mcg / 2mL vial	BID
<input type="checkbox"/> Pulmicort	— 0.25mg/2mL / BID <input type="checkbox"/> 0.5mg/2mL / BID — 1mg/2mL / Once Daily Respules	
<input type="checkbox"/> Tobramycin	— 300mg/5ml inhalation solution — 300mg every 12 hours for 28 days, followed by 28 days off of medication — QTY 56 ampules	
<input type="checkbox"/> Acetylcysteine 20% solution	3mL	<input type="checkbox"/> Once Daily <input type="checkbox"/> BID — TID — QID — Other _____
<input type="checkbox"/> Budesonide	— 0.25mg/2mL — 0.5mg/2mL	<input type="checkbox"/> Once Daily <input type="checkbox"/> BID — TID — QID — Other _____
<input type="checkbox"/> Lonhala 25mcg/1ml vial		<input type="checkbox"/> BID — First Time Starter Kit — Refills _____
<input type="checkbox"/> Albuterol 0.83% (2.5mg/3mL)		<input type="checkbox"/> Once Daily <input type="checkbox"/> BID — Other _____
<input type="checkbox"/> Albuterol 2.5mg / Ipratropium 0.5mg/3mL		<input type="checkbox"/> Once Daily <input type="checkbox"/> BID — TID — QID — Other _____
<input type="checkbox"/> Albuterol 0.5% / 20mL SIG: _____ mL		<input type="checkbox"/> Once Daily <input type="checkbox"/> BID — TID — QID — Other _____
<input type="checkbox"/> Ipratropium 0.02% (0.5mg/2.5mL)		<input type="checkbox"/> Once Daily <input type="checkbox"/> BID — TID — QID — Other _____
<input type="checkbox"/> Nebulizer		
<input type="checkbox"/> Reusable Nebulizer Kit (1/6 months)		

**Add-on items only
 To be ordered in
 addition to any
 medication listed
 above**

Length of need: Lifetime Other _____ months

Patient will require training

PHYSICIAN SIGNATURE REQUIRED

X _____ **X** _____
 DISPENSE AS WRITTEN (Date) PRODUCT SUBSTITUTION PERMITTED (Date)

Specialty: Allergist Primary Care ENT Pulmonologist Pediatrician Other: _____

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to Vasco Rx Pharmacy and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.