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

☐ J44.9 Simple Chronic Bronchitis
☐ J44.9 Obstructive chronic bronchitis without exacerbation
☐ J44.9 Chronic airway obstruction, not elsewhere classified
☐ J44.0 With acute broncitis
☐ J44.1 With (acute) exacerbation
☐ Other_____

☐ J41.1 Mucopurulent chronic bronchitis
☐ J43.9 Other emphysematous
☐ R23.8 Emphysematous bleb

PRESCRIPTION INFORMATION Nebulized Medications

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

X PHYSICIAN SIGNATURE REQUIRED

DISPENSE AS WRITTEN (Date)

X

PRODUCT SUBSTITUTION PERMITTED (Date)

Specialty: ☐ Allergist ☐ Primary Care ☐ ENT ☐ Pulmonologist ☐ Pediatrician ☐ Other: _____