Express Rx Pharmacy and Medical Supplies
1711 W. Temple St #100
Los Angeles, CA 90026
Phone: 855-349-6017 Fax: 213-674-3197

Medical Necessity & Prescription Form for FEEDING Supplies

Patient Name: _____ DOB: _____ Gender: M F
Address: _____
Telephone: _____ Insurance ID#: _____

Diagnosis: _____ **ICD-9 Code**: _____

Formula _____
Daily Use _____ oz by g-tube / orally every _____Hours, QS for 30 day supply.
Feeding Bags: Brand _____ Choose: 500ml or 1000ml or _____
Use 1 bag daily as directed #30 / Month

Mic-Key Extension sets / (circle choices) **6 sets / max per month**
Daily Usage: Use _____ as directed.

NON-BOLUS, y-port:	**NON-BOLUS,** right-angle:	**BOLUS,** straight
0121-12 (12")	0124-12 (12")	01-23-12 (12")
0121-24 (24")	0124-24 (24")	01-23-24 (24")

Mic-Key Feeding Tube (must specify) French Size: [ ] fr Length [ ] cm
Dispense: 1 tube every 60 days, change prn

Catheter-Tip Syringe Size: [ ] 60ccl [ ] 20cc [ ] 10cc [ ] 5cc
Daily usage: Use _____ as directed per month.

Spanish Labeling: Y N **30 DAY SUPPLY** **Refills _____ / or 1 year**

Physician Declaration: I have reviewed the above named patient's medical records and the items ordered. I certify that these items are medically necessary for this patient's condition. I authorize these items that are checked to be filled and dispensed as ordered. I certify that the checked diagnosis is an accurate statement and is reflected in the patient's medical records / charts.

Physician Signature: _____ **Date:** _____
Physician Name: _____ **DEA:** _____**NPI #**_____
Address: _____
Office Contact Person: _____ **Phone:** _____