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CHAD WOJNAR R.PH., PRESIDENT
JACK LOVELAND R. PH., VICE PRESIDENT

Physician's Order Form for Nebulizer Therapy

Date Ordered: _____ ☐ **Initial** ☐ **Renewal** **Date Of Exam:** _____

Patient Name: _____ **DOB:** _____

Patient Address: _____

Height: _____ **Weight:** _____

Insurance ID #: _____ **Length of Need:** _____

Equipment & Supplies

Please Indicate:

☐ **Nebulizer (E0570)**
☐ **Reusable Neb Kit (A7005)**- 1 per 6 months
☐ **Disposable Filters (A7013)**- 2 per month
☐ **Aerosol Mask (A7015)**- 1 per month

OR

☐ **Disposable Neb Kit (A7003)**- 2 per month
☐ **Tracheostomy Mask (A7525)**- 1 per month

Patient Diagnosis- Please indicate correct ICD- 10 Code(s): _____
(Mucomyst is covered for all codes.)

Medications

☐**Albuterol-** Unit Dose 0.83mg/ml 25 vials/box
Directions: Nebulize 1 vial ___ times daily **or** every ___ hours
Dispense 30 day supply **or** ___ Refills: ___

☐**Albuterol-** Soln 5mg/ml 20ml/box
Directions: Nebulize __ ml ___ times daily **or** every ___ hours
Dispense 30 day supply **or** ___ Refills: ___

☐**Ipratropium-** Unit Dose 0.02%/vial 25 vials/box
Directions: Nebulize 1 vial ___ times daily **or** every ___ hours
Dispense 30 day supply **or** ___ Refills: ___

☐**Pulmicort-** Unit Dose 0.25mg/2ml 30 vials/box
Directions: Nebulize 1 vial ___ times daily **or** every ___ hours
Dispense 30 day supply **or** ___ Refills: ___

☐**Pulmicort-** Unit Dose 0.5mg/2ml 30 vials/box
Directions: Nebulize 1 vial ___ times daily **or** every ___ hours
Dispense 30 day supply **or** ___ Refills: ___

☐**Brovana-** Unit Dose 15mcg/2ml 60 vials/box
Directions: Nebulize 1 vial ___ times daily **or** every ___ hours
Dispense 30 day supply **or** ___ Refills: ___

☐**Mucomyst-** 10% 30 ml/vial
Directions: Nebulize __ ml ___ times daily **or** every ___ hours
Dispense 30 day supply **or** ___ Refills: ___

Physician Name: _____ **NPI #** _____

Physician's Address: _____

I, the undersigned, certify the above prescribed equipment and/or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and/or supplies prescribed are both reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition. Neither the equipment and/or supplies are being prescribed as "convenience equipment".

Physician's Signature : _____ **Date Signed:** _____

LC