

**RESPIRATORY MEDICATION PRESCRIPTION**

FAX to: 1-866-317-0829 or Call 1-866-901-4507



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Patient Phone: (Day) \_\_\_\_\_ (Alt) \_\_\_\_\_ SS# \_\_\_\_\_

The **PATIENT** listed above has requested that we provide respiratory medications and related supplies to assist in their health management program. Please complete items **1 thru 4** carefully, provide signature and date, and FAX completed form to:  
**1-866-317-0829**

Doctor Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Doctor Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Doctor Phone: \_\_\_\_\_ FAX: \_\_\_\_\_ NPI # \_\_\_\_\_ Medicaid # \_\_\_\_\_

**PRESCRIPTION**

**1. Start Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**DIAGNOSIS (required):**  COPD (496)  Emphysema – other (492.8)  Bronchitis (491.9)  Asthma – unspecified (493.90)  
 Other: \_\_\_\_\_

**2. MEDICATION (required):**  
 Albuterol 0.083% 3ml Unit Dose  
 Ipratropium 0.02% 2.5 ml Unit Dose  
 Pulmicort 0.25MG 2 ml  
 Other: \_\_\_\_\_  
 Other: \_\_\_\_\_

**FREQUENCY (required):**  
 BID  TID  QID  Other: \_\_\_\_\_  
 BID  TID  QID  Other: \_\_\_\_\_  
 BID  TID  QID  Other: \_\_\_\_\_  
 BID  TID  QID  Other: \_\_\_\_\_

**Refills:** 12 months or Other: \_\_\_\_\_ **Quantity:** 1 month or Other: \_\_\_\_\_

**3. EQUIPMENT PRESCRIBED:** **LENGTH OF NEED:** Lifetime, unless otherwise specified: \_\_\_\_\_  
 Patient has Nebulizer System  
 Company to ship the Nebulizer System to patient  
 **MEDICATION ONLY**  
 Nebulizer kits (2 sets of disposable tubing and 1 nebulizer cup every 30 days)  
 Adult mask (1 every 30 days)  
 Other: \_\_\_\_\_

**4.** By my signature below, I state that:  
 (a) I am or was treating this patient for the indicated diagnosis on the effective date of this order, (b) This order accurately reflects this patient's diagnosis and condition and is substantiated by my medical records, (c) The patient or their caregiver is (or is scheduled to be) trained in the use of the nebulizer system, medications, nebulizer kits, cups, masks, and filters, and (d) I will make the original signed copy of this document a part of this patient's medical records and make it available to Medicare, Medicaid, and other insurers, Support Plus Medical, Inc., or any authorized agent, if requested.

**SIGNATURE:** \_\_\_\_\_ **NPI #** \_\_\_\_\_ **DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_