



Prescription Order Form
Fax to (877) 291-1155

Patient Information:

Name _____ Male Female Date _____
Address _____ City _____ State _____ ZIP _____
Social Security # _____ Date of Birth _____ Allergies _____
Home Phone _____ Work Phone _____ Email _____
Emergency Contact _____ Phone _____ Relationship _____

Please Attach a Copy of Insurance Card(s)
(Front and Back)

Diagnosis / ICD9 Code _____

Equipment: Trio® Nebulizer PARI LC® Plus Nebulizer Other _____

Medications:

(Circle One)

(Circle One)

Albuterol	<input type="checkbox"/> 2.5mg/3ml	<input type="checkbox"/> 2.5mg/0.5ml	<input type="checkbox"/> 1.25mg/3ml	QD	BID	Other _____	QTY _____	
Albuterol Solution 5mg/ml 20ml	<input type="checkbox"/> 0.5ml	<input type="checkbox"/> 0.25ml		QD	BID	Other _____	QTY _____	
Cayston® with Altera® Nebulizer		<input type="checkbox"/> 75mg		TID			28 Days	Monthly or Every Other Month
Colistimethate	<input type="checkbox"/> 75mg	<input type="checkbox"/> 150mg		QD	BID	Other _____	QTY _____	Monthly or Every Other Month
	<input type="checkbox"/> Premixed	<input type="checkbox"/> Powder with:		sterile water	sodium chloride			
Hyper-Sal™	<input type="checkbox"/> 7% / 4ml			QD	BID	Other _____	QTY _____	
Hypertonic Saline	<input type="checkbox"/> _____%	_____ml		QD	BID	Other _____	QTY _____	
Pulmozyme®	<input type="checkbox"/>			QD	BID	Other _____	QTY _____	
TOBI®	<input type="checkbox"/> 300mg/5ml			QD	BID	Other _____	QTY _____	Monthly or Every Other Month
Tobramycin	<input type="checkbox"/> 150mg/3ml	<input type="checkbox"/> 170mg/3.4ml		QD	BID	Other _____	QTY _____	Monthly or Every Other Month
Xopenex®	<input type="checkbox"/> 0.63mg	<input type="checkbox"/> 1.25mg	<input type="checkbox"/> HFA	QD	BID	Other _____	QTY _____	
ZENPEP™	<input type="checkbox"/> 5,000 USP lipase units	<input type="checkbox"/> 10,000 USP lipase units	<input type="checkbox"/> 15,000 USP lipase units	<input type="checkbox"/> 20,000 USP lipase units				Sig/Directions: _____

Refill for 1 Year
or _____

Other _____ **Sig/Directions:** _____

Prescribing Physician Information:

Physician Signature _____ / _____ Date _____
(Substitutions Permitted) (Dispense as Written)

Physician Name _____ Practice/Facility Name _____ Physician Specialty _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Fax _____ Email Address _____

DEA # _____ NPI # _____

Name of Contact Person _____ Contact Person #, ext or email _____