Forms needed for new respiratory medications order or nebulizer compressor referred directly from Physician:

1. Completed Fax Cover Sheet (please include Physician name and practice, as well as DME company name).
2. Respiratory Medication Prescription order form (necessary for **ALL** referrals).
3. Patient Progress Notes (only necessary for orders including Nebulizer equipment).
4. Physician Practice Cover Sheet (please staple to above mentioned forms).
5. Physician Starter Dose Form (optional).

Comments/ Notes:

Any questions please call 800-638-6305 for Order Intake.

orderintake@abcplus.net **Fax: 800-638-0294**

1825 EVERETT DR, WEST
FORT PAYNE, ALABAMA 35968
PHONE: (800)638-6305
FAX: (800)638-0294

PHYSICIANS DIRECT FAX COVER

FACSIMILE TRANSMITTAL SHEET

TO:
ABC Plus Pharmacy

FROM (PHYSICIAN PRACTICE):

PREFERRED DME COMPANY:

DATE:

FAX NUMBER:
800-638-0294

TOTAL NO. OF PAGES INCLUDING COVER:

PHONE NUMBER:
800-638-6305

PRACTICE PHONE NUMBER:

Patient Name:

YOUR REFERENCE NUMBER:
ABC PLUS INFO: Customer Service

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY

NOTES/COMMENTS:

Confidentiality Note: The documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.

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Respiratory Medication Prescription **Referring Company**______________________________

PATIENT INFORMATION

Patient Name ______________________________

Address ______________________________

City, State Zip ______________________________

Home Phone ______________________________

Emergency Phone ______________________________

Date of Birth ______________ Gender __________

Social Security # ______________________________

PHYSICIAN INFORMATION

Physician Name ______________________________

Address ______________________________

City, State Zip ______________________________

Phone ______________________________

Fax ______________________________

UPIN / NPI ______________ / ______________

Nurse/Contact Person ______________________________

Name of Insured ______________________________

INSURANCE INFORMATION

Primary:______________________________ Policy#__________________ Group#______________ Phone______________

Secondary:______________________________ Policy#__________________ Group#______________ Phone______________

DIAGNOSIS:

____496 (COPD) ____493.90 (Asthma) ____491.9 (Chronic Bronchitis) ____492.8 (Emphysema) ____494.0 (Bronchiectasis) ____Other_______

MEDICATION (Please Check Prescribed Meds)	**FREQUENCY/DIRECTIONS** (Please Check Frequency of Dosage)
☐ Gen. DuoNeb (Ipr 0.02% 0.5mg/Alb 0.083% 2.5mg/3.0ml)	___QID(#120) four daily ___TID(#90) three daily ___BID(#60) twice daily ___AND PRN_____
☐ Albuterol 0.083% 2.5mg/3.0ml	___QID(#120) four daily ___TID(#90) three daily ___BID(#60) twice daily ___AND PRN_____
☐ Ipratropium 0.02% 0.5mg/2.5ml	___QID(#120) four daily ___TID(#90) three daily ___BID(#60) twice daily ___AND PRN _____
☐ Budesonide 0.25mg/2ml	___BID(#60) twice daily ___QD(#30) once daily
☐ Budesonide 0.5mg/2ml	___BID(#60) twice daily ___QD(#30) once daily
☐ Perforomist 20mcg/2ml	___BID(#60) twice daily ___QD(#30) once daily
☐ Brovana 15mcg/2ml	___BID(#60) twice daily ___QD(#30) once daily
☐ **Tobramycin 300mg/5ml**	___**BID twice daily (56 vials, 28 day supply)**
☐ Other ______________________________	______________________________

Order Good for TWELVE MONTHS, Unless Otherwise Noted.

Start Date: ____________________

➔ **Refills**: ______ **Please circle one:** 12 months 6 months 3 months **Other:**________

➔ **Circle Quantity -** 90 days 30 days

☐ **E0570 Nebulizer(Compressor)** ☐ **E0571 Portable AC/DC (Compressor)** **Length of need** __99__ **months (99= lifetime)**

*Medicare Part B coverage allows for a monthly prescription of 2 doses of Brovana or Perforomist per day. In addition, Medicare Part B also allows for a prescription of 30 doses of a nebulized short-acting beta-agonist per month as a rescue/supplemental medication when Brovana or Perforomist is prescribed. Note that this coverage determination does not affect metered-dose inhaler (MDI) SABAs (Medicare Part D benefit) or nebulized ipratropium bromide (Medicare Part B benefit).

MD/DO/NP/PA Signature (Required)

X____ ______________ ____

Product Selection Permitted *Date* *Dispense as written*

REQUEST FOR PHYSICIAN STARTER DOSES

PHYSICIAN STARTER DOSES WILL BE SHIPPED VIA UPS SUREPOST
FAX TO (800) 638-0294

Date ___/___/___

Physician Name ______________________________

Address ______________________________

City, State Zip ______________________________

NPI# ______________ Phone ______________ Fax ______________

Authorized Person ______________________________

Special Instructions (if any) ______________________________

Description	Vial Size	Units per Carton	Qty. Per Order	Check Desired Item
Albuterol 0.083%, 2.5mg, unit dose	3.0 mL	60	1 Carton	
Ipratropium 0.02%, 0.5mg, unit dose	2.5mL	60	1 Carton	
Ipr 0.5mg/Alb 3.0mg, unit dose *(Generic Duoneb)*	3.0 mL	60	1 Carton	

Physician's Signature ______________________________

DISCLAIMER: MODIFICATIONS TO THIS FORM MAY RESULT IN DELAY OR NULLIFICATION. IF A MEDICARE PROVIDER, PHYSICIAN **MUST** BE PECOS ENROLLED IN ORDER TO RECEIVE ANY SAMPLES.