ASL PHARMACY™ 900 Calle Plano, Suite M • Camarillo, CA 93012 • Tel 866-552-7579 • Fax 866-442-7579

1. PATIENT INFORMATION

Patient Name: _____

DOB: _____/_____/_____ Age: _____ M _____ F_____

Address: _____

City: _____ ST:_____ Zip: _____

Tel: Home _____ Work _____ Cell _____

Medical Insurance: (or fax copy of card) _____

ID #: _____ Group #:_____

Ins Tel # : _____ Ins Fax#: _____

2. EQUIPMENT

☐ **CHECK THIS BOX. Equipment Ordered by Physician: Sinus Science™ Aerosol Delivery System Nasal Nebulizer. All medications require the Sinus Science™ Nebulizer on the first Rx.**

3. PRESCRIPTION

Unit-dose medications prescribed by physician. All medications listed are for use in the Sinus Science™ Aerosol Delivery System Nebulizer. Check box left of medication for recommended dose: TID for 21 days or indicate alternate dose, frequency and/or duration.

Check Here for Recommended Dose (TID for 21 Days)

Alternate Dosing

Antibiotics

- ☐ Ceftazidime (650 mg) Dose ____ Sig ____ Days ____ Refill ____
- ☐ Ceftriaxone (500 mg) Dose ____ Sig ____ Days ____ Refill ____
- ☐ Vancomycin (285 mg) Dose ____ Sig ____ Days ____ Refill ____
- ☐ Tobramycin (125 mg) Dose ____ Sig ____ Days ____ Refill ____
- ☐ Amikacin (120 mg) Dose ____ Sig ____ Days ____ Refill ____
- ☐ Levofloxacin (100 mg) Dose ____ Sig ____ Days ____ Refill ____
- ☐ Clindamycin (150 mg) Dose ____ Sig ____ Days ____ Refill ____
- ☐ Mupirocin (3.3 mg) Dose ____ Sig ____ Days ____ Refill ____
- ☐ Other _____ Dose ____ Sig ____ Days ____ Refill ____

Mucolytics

- ☐ Acetylcysteine (200 mg) Dose ____ Sig ____ Days ____ Refill ____

Anti-inflammatories

- ☐ Pulmicort™ Respules (0.5 mg) Dose ____ Sig ____ Days ____ Refill ____
- ☐ Mometasone (0.6 mg) Dose ____ Sig ____ Days ____ Refill ____
- ☐ Budesonide (0.6 mg) Dose ____ Sig ____ Days ____ Refill ____
- ☐ Betamethasone (0.5 mg) Dose ____ Sig ____ Days ____ Refill ____

Anti-fungals

- ☐ Itraconazole (40 mg) Dose ____ Sig ____ Days ____ Refill ____
- ☐ Fluconazole (40 mg) Dose ____ Sig ____ Days ____ Refill ____
- ☐ Amphotericin B (5 mg) Dose ____ Sig ____ Days ____ Refill ____

4. DIAGNOSIS

- ☐ 473.9 Chronic Sinusitis, Unspecified
- ☐ 477.9 Allergic Rhinitis, Unspecified
- ☐ 473.0 Chronic Sinusitis, Maxillary
- ☐ 473.2 Chronic Sinusitis, Ethmoidal
- ☐ 461.8 Acute Sinusitis, Pansinusitis
- ☐ 117.90 Mycoses, Unspecified
- ☐ 493.90 Asthma, Unspecified
- ☐ 461.9 Acute Sinusitis, Unspecified
- ☐ 473.1 Chronic Sinusitis, Frontal
- ☐ 473.3 Chronic Sinusitis, Sphenoidal
- ☐ 473.8 Chronic Sinusitis, Pansinusitis
- ☐ Other _____

5. MEDICATION ALLERGIES

1. _____ 2. _____ 3. _____

Culture/Sensitivity: Yes___ No ___ Organism: _____

Comments: _____

6. PHYSICIAN VERIFICATION

I have reviewed my patient's medical record and determined the medication/supplies ordered are medically necessary. I verify I have examined and diagnosed the patient as indicated above. I will comply with state and federal documentation requirements by retaining a copy of this prescription in the patient's medical record. The prescription is to be dispensed as written unless otherwise instructed by me.

Physician: _____

Signature: _____ **Date:**_____ **Office Contact:**_____

Address: **City:** **ST:** **Zip:**

DEA #: **State License #:**

NPI #: **Phone:** **Fax:**

Fax completed form to ASL PHARMACY™ at 866-442-7579