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

Rx

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: Nasal Nebulizer. All medications require the approved Nasal Nebulizer device on the first Rx.**

3. PRESCRIPTION

Unit-dose nebulized medications prescribed by physician. Dispense as directed. 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 (160 mg) Dose _____ Sig _____ Days _____ Refill _____
- ☐ Tobramycin (125 mg) Dose _____ Sig _____ Days _____ Refill _____
- ☐ Levofloxacin (100 mg) Dose _____ Sig _____ Days _____ Refill _____
- ☐ Clindamycin (150 mg) Dose _____ Sig _____ Days _____ Refill _____
- ☐ Other _____ Dose _____ Sig _____ Days _____ Refill _____

Anti-inflammatories

- ☐ Budesonide (0.6 mg) Dose _____ Sig _____ Days _____ Refill _____
- ☐ Mometasone (0.6 mg) Dose _____ Sig _____ Days _____ Refill _____
- ☐ Betamethasone (0.5 mg) Dose _____ Sig _____ Days _____ Refill _____
- ☐ Pulmicort® (0.5 mg) Dose _____ Sig _____ Days _____ Refill _____

Anti-fungals

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

(mcode: CT)

Mucolytic

- ☐ Acetylcysteine (200 mg) Dose ____Sig ____Days ____Refill ____

Combinations Available: TID x 21 Day Dosing

- ☐ Tobramycin (125 mg) + Betamethasone (0.5 mg) Dose ____Sig ____Days ____Refill ____
- ☐ Vancomycin (160 mg) + Betamethasone (0.5 mg) Dose ____Sig ____Days ____Refill ____
- ☐ Levofloxacin (100 mg) + Betamethasone (0.5 mg) Dose ____Sig ____Days ____Refill ____

- ☐ Tobramycin (125 mg) + Amphotericin B (5 mg) + Betamethasone (0.5 mg) Dose ____Sig ____Days ____Refill ____
- ☐ Mupirocin (3.3 mg) + Tobramycin (125 mg) + Betamethasone (0.5 mg) Dose ____Sig ____Days ____Refill ____
- ☐ Levofloxacin (100 mg) + Amphotericin B (5 mg) + Betamethasone (0.5 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.

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

Physician: _____

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

State License #: _____ **NPI #:** _____

Phone: _____ **Fax:** _____

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