promptcare™

Respiratory Referral Form

Phone: 866-451-8804
Fax: 877-451-8955
Email: COPD_Program@promptcare.com

Patient Information ☐ New Rx ☐ Refill

Name | Date of Birth | Home Phone Number | Other Phone Number

Address | City | State | Zip

Patient | ☐ Allergies | ☐ No Known Allergies

Insurance Info [Fax a copy of the patient's insurance card (both sides).]

Doctor/Prescriber Info [NPI # is mandatory .]

Name | Office Contact

Address | City | State | Zip

NPI # | Phone # | Fax #

Statement of Medical Necessity *** Please Fax recent clinical notes, tests with the prescription.

Medicare/Medicaid maximum allowed **Length of Need** is 12 months. Date Last Seen:

Length of Need: months (99=Lifetime) Diagnosis/ICD-10:

Medication	Dose/Strength	Frequency/Directions
☐ Budesonide (Pulmicort Flexhaler)	☐ 90mcg/dose ☐ 180mcg/dose	☐ 2 puffs BID 90 day supply ☐ 1 puff BID 90 day supply
☐ Albuterol/Ipratropium (DuoNeb)	☐ 2.5-0.5mg/3ml	☐ QID (360 vials) ☐ TID (270 vials) ☐ BID (180 vials) ☐ QD (90 vials)
☐ Albuterol Sulfate	☐ 0.63mg/3ml ☐ 1.25mg/3ml ☐ 2.5mg/3ml	☐ QID (360 vials) ☐ TID (270 vials) ☐ BID (180 vials) ☐ QD (90 vials)
☐ Arformoterol Tartrate (Brovana®)	☐ 15mcg/2ml	☐ BID (180 vials) ☐ QD (90 vials)
☐ Budesonide® (Pulmicort®)	☐ 0.25mg/2ml ☐ 0.5mg/2ml	☐ BID (180 vials) ☐ QD (90 vials)
☐ Ipratropium Bromide	☐ 0.2mg/ml	☐ QID (360 vials) ☐ TID (270 vials) ☐ BID (180 vials) ☐ QD (90 vials)
☐ Perforomist® (formeterol fumarate)	☐ 20mcg/2ml	☐ BID (180 vials) ☐ QD (90 vials)
☐ Lonhala Magnair Starter Kit (30 foil pouches with 2 vials per pouch)	☐ 25mcg/ml	☐ BID (1 kit with 60 vials)
☐ Lonhala Magnair Refill Kit (60 foil pouches with 2 vials per pouch)	☐ 25mcg/ml	☐ BID (3 kits with 180 vials)
☐ Tobramycin (Tobi®)	☐ 300mg/5ml	☐ Monthly - 1 vial BID (56 vials, 28 day supply) ☐ Every other month - 1 vial BID (56 vials, 56 day supply) **Refills:**________

Medication Administration Supplies:

☐ Nebulizer/Compressor (E0570) ☐ Trach Mask 1/mo (A7525) ☐ Disposable Filter 1/2mo (A7013)

☐ Disposable Neb Kit 1/mo (A7003) ☐ Reusable Neb Kit 1/6 mo (A7005) ☐ Mask 1/mo (A7015)

Doctor/Prescriber Signature ____________ Date ____________

Federally approved, generic equivalent medications will be dispensed for brand name medications unless otherwise directed by the patient, physician or health plan. I authorize PromptCare and it's representatives to act as an agent to initiate & execute the insurance prior authorization and any future fills of the same prescription for the patient listed above. I understand that I may revoke this right at any time by providing written notice to PromptCare.

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