Fax: (913) 273-1468 Toll-Free: 1800-746-9120

ORDER FORM FOR LOWER RESPIRATORY DELIVERY

Patient's Name: ______________________________ **Date of Birth:**______________________________
Patient's Address: ______________________________ **Email:**______________________________
Home Phone Number: ______________________________ **Cell Phone Number:**______________________________
Patient's Allergies:____

Prescription Signature: ____
Prescriber: ______________________________ **Person Faxing:** ______________________________
DEA: ______________________________ **NPI:** ______________________________
Address: ____
Phone: ____________________ **Fax:** ____________________ **Email:**______________________________

PLEASE FAX COPIES OF BOTH MEDICAL AND PRESCRIPTION CARDS **Required Fields

I have indicated by number(s) below, in order of preference, the medication(s) I am prescribing. The pharmacy shall dispense my first preference, unless not covered by the patient's insurance, in which case the pharmacy shall proceed in similar manner based on my order of preference. The pharmacy may dispense any drug selected below, regardless of order of preference, based on the patient's choice.

COMMONLY REQUESTED MEDICATIONS: (CMPD refers to medication compounded by pharmacy)

- ❑ CMPD001: **Tobramycin 160 mg - Levofloxacin 125 mg** Capsule (RX Temp 1512)
- ❑ CMPD002: **Levofloxacin 125 mg** Capsule (RX Temp 1620)
- ❑ CMPD003: **Colistimethate 150 mg** Capsule (RX Temp 1603)
- ❑ CMPD004: **Gentamicin 80 mg** Capsule (RX Temp 0172)
- ❑ CMPD005: **Acetylcysteine 600 mg** Capsule (RX Temp 0867)

Other____

COMMERCIALLY AVAILABLE

- ❑ CMA001: **Meropenem 500 mg** Vail
- ❑ CMA002: **Ceftriaxone 500 mg** Vail

Other____

DIRECTIONS

- ❑ Apply 1 dose in Neblizer system to deliver medication into lungs, repeat 3 times per day.
- ❑ Apply 1 dose in Neblizer system to deliver medication into lungs, repeat 2 times per day.
- ❑ Other: ____

Quantity to Dispense:____________________ days (30 day supply unless otherwise indicated here)

Refills: ❑ ❑2 ❑3 ❑4 ❑5 ❑1yr

❑ I AUTHORIZE THE PHARMACIST AND/OR PHARMACY STAFF TO ACT AS MY AGENT TO ACQUIRE A PRIOR AUTHORIZATION ON THIS PRESCRIPTION

REP ID [ ]