36

EXHIBIT 36

CONCERN CARE PHARMACY

888-370-2600 Phone 888-370-5060 Fax

Date of Service _____

(Rep 01)

–LETTER OF MEDICAL NECESSITY–

PATIENT NAME_____ SEX : M F DOB:_____

ADDRESS_____

CITY, ST. ZIP_____ PHONE (___) _____

DIAGNOSIS

_____ BRONCHITIS 491.0 _____ CHRONIC BRONCHITIS 491.2 _____ EMPHYSEMA 492.8

_____ ASTHMA 493.20 _____ BRONCHIECTASIS 494 _____ COPD 496

_____ ABNORMAL SPUTUM 786.4 _____ OTHER

Is the patient's breathing severely impaired _____yes _____no

Prognosis: ____Good ____ Fair ____ Poor Estimated Length of Need _____ Months (If lifetime=99)

MEDICATION	*DOSAGE*	*BRAND NAME*	*FREQUENCY*
_____ALBUTEROL Sulfate	2.5mg (3ml)	PROVENTIL, VENTOLIN ®	____2 X DAILY (BID) #60 FOR 30 DAYS
_____IPRATROPIUM Bromide	.5mg (3ml)	ATROVENT ®	
_____IPRATROPIUM Bromide	.75mg (2ml)	ATROVENT ®	
_____BUDESONIDE	.4mg (2ml vial)	PULMOCORT ®	____3 X DAILY (TID) #90 FOR 30 DAYS
_____BUDESONIDE	.6mg (2ml vial)	PULMOCORT®	
			____4 X DAILY (QID) #120 FOR 30 DAYS

COMBINATIONS

___ALBUTEROL / IPRATROPIUM (2.5ML)
2.5MG / .75MG

___ALBUTEROL / IPRATROPIUM (2.5ML)
1.25MG / .75MG

_____OTHER
PRN

OTHER_____

REFILLS _____

NEBULIZER CIRCUIT KITS AND CUPS WILL BE PROVIDED (if applicable)

Physician's Name_____ UPIN _____

Address_____ Phone (___) _____

I certify active treatment on the above patient. The medication is to be utilized in a Nebulizer Compressor and is part of my course of treatment and is medically necessary for the above stated condition. The use of a MDI has been considered and ruled out. To my knowledge, all of the above information is true and correct.

_____ _____

Certifying Physician's Signature *Date Signed*

FAX TO 888-370-5060

NationalHealth

- Prescription -

Respiratory Medications and Supplies

Any fields pre-filled reflect your previous written prescription, or were confirmed verbally with your office by our pharmacist

Instructions: Please fill in ALL sections and fax back toll free to 1(800) 977-0601
If you have any changes, please cross out, write in correction, sign and date form.

Toll Free Fax #
1(800) 977-0601
RID=000000061798

PATIENT [redacted]
Phone: [redacted]
HICN: [redacted]
Birth date: [redacted]
Our ID #: [redacted]

PHYSICIAN [redacted]
Phone: [redacted]
Fax #: [redacted]

Start Date: _____ (as confirmed with office, if none then date signed)

1 **Check Appropriate Diagnosis:**
☐ 496COPD ☐ 492.8 Emphysema ☐ 491.9 Chronic Bronchitis ☒ 493.90 Asthma
☐ 786.4 Persistent pulmonary secretions-abnormal fluid(Acetylcysteine prescriptions only)

2 I am prescribing a Compressor Nebulizer E0570 unless otherwise noted below:

3 **Supplies** Please send: (one only) Disposable Nebulizer Tubing w/ Mask OR the Nebulizer option checked below
☐ Non-Disposable Nebulizer Tubing with Mask
☐ Tracheotomy Collar w/ Nebulizer ☐ Other

4
☐ ALBUTEROL SULFATE 0.083% 3mL UD 0.5 mL Albuterol 0.5% IN 2.5mL Normal Saline
☒ ALBUTEROL SULFATE 0.083% IN 3mL Normal Saline & IPRATROPIUM BROMIDE 0.02% IN 2.5mL Normal Saline (Separate UD vials)
☐ ACETYLCYSTEINE 10% 4mL UD(For abnormal fluid diagnosis only)
☐ METAPROTERENOL 0.4% 2.5mL UD
☐ METAPROTERENOL 0.6% 2.5mL UD
☐ IPRATROPIUM BROMIDE (Atrovent)0.02% IN 2.5mL Normal Saline UD
☐ CROMOLYN SODIUM UD 20mg/2mL Sterile Water
☐ SODIUM CHLORIDE 0.9% 3mL/dose UD
☐ ACETYLCYSTEINE 20% 4mL UD(For abnormal fluid diagnosis only)
☐ ALBUTEROL SULFATE 3.0 mg with IPRATROPIUM BROMIDE 0.5 mg/3ml (Premixed)

Steroid Products:
☐ BUDESONIDE (pulmicort)0.25mg/2mL
☐ BUDESONIDE (pulmicort)0.5mg/2mL

* The listed choices are only some possible therapies and others may be clinically appropriate.

5 **Times Per Day Treatment:** (MUST check ☒ one) ☐ QD ☐ BID ☐ TID ☒ QID ☐ Q4H ☐ Other (Medicare does not accept "PRN")

6 If treatment regimen exceeds 4 times per day, Medicare requires a detailed explanation of the reason: (✓ all that apply)
☐ Obstructed Airway (progressive inelasticity of the lungs) ☐ Crackling and Congestion in the lungs ☐ Pneumonia
☐ Obstructed Breathing(inflammation of bronchial tubes) ☐ Bronchial Spasms ☐ Wheezing _____
☐ Increased Asthmatic Breathing Difficulty ☐ Shortness of Breath ☐ Other: _____
* If treatment regimen exceeds 6 times per day, this completed form must be accompanied by a Letter of Medical Necessity signed by the physician on his or her letterhead.

7 Medicare maximum allowed duration of need is 12 months. Duration of need 12 months or if not otherwise specified (NOS), then 12 months.

By my signature below, I authorize the use of this document by a licensed pharmacy as a dispensing prescription. I have considered the use of a metered dose inhaler (MDI) with and without a reservoir or spacer device and decided that, for medical reasons, it was not sufficient for the administration of the prescribed inhalation drug(s). I certify that the information contained herein is a true and correct verification of my verbal or written order and that my medical records support the medical need for the items prescribed. I will maintain for Medicare/insurance requirements this signed original document in the patient's medical record file for post-payment review/audit purposes.

8 Physician Signature [signature] Date 2/31/04 9

10 UPIN E27706 If UPIN is incorrect, correct UPIN here_____, print name_____

RESPIRATORY SERVICES

Phone: (770) 454-7668
Fax: (770) 454-7664
Toll Free Phone: (866) 454-7668
Toll Free Fax: (866) 454-7664

Order Form

Date: _____

☐ New Order ☐ Reorder ☐ Change

Patient Name: _____

Address: _____

City/State/Zip: _____

Phone # 1: _____

Phone # 2: _____

Date of Birth: _____ (M or F) _____

Diagnosis: _____

Diagnosis CODE: _____

If child, parent or guardian: _____
(please print name)

Practice Name: _____

Address: _____

_____

PH: _____ FAX: _____

Physician: _____

UPIN #: _____ GA License: _____

DEA #: _____ GBHC#: _____

Practice Contact: _____

INSURANCE INFORMATION

Medicare #: _____ Medicaid #: _____

Other Insurance

Company Name: _____ Phone: _____

Policy #: _____ Group #: _____

MEDICATION

☐ Albuterol .083% / 2.5mg/3ml
☐ Ipratropium Bromide 0.02% / .5mg/2.5ml
☐ Compound (Albuterol 2.5mg / Ipratropium .5) 3ml

☐ Pulmicort 0.25 mg respules Sig: BID ☐ QD ☐ (Medicaid)
☐ Pulmicort 0.50 mg respules Sig: BID ☐ QD ☐ (Medicaid)
☐ Budesonide 400mcg cmpd Sig: BID ☐ QD ☐ (Medicare)

Other Medications: _____

☐ QID ☐ TID ☐ Q4H ☐ Q6H ☐ Other _____

Dispense: 1 month supply with PRN refills for a year _____ OR **DISPENSE** _____ **with** _____ **REFILLS**

EQUIPMENT

Will Respiratory Services provide the nebulizer? ☐ Yes (Serial #: _____) ☐ No

Respiratory Services customers will receive nebulizer circuits and a complimentary cleansing bucket with Control III Disinfectant.

DELIVERY of Medications AND/OR Nebulizer

Respiratory Services will ship all orders to arrive on the next business day unless otherwise specified by the physician.

Comments: _____

Physician's Signature _____

CONFIDENTIAL PATIENT INFORMATION

Bright Medical Technologies
Respiratory Medication Prescription Order

1-800-345-4268
215-942-7989 (FAX)

PATIENT Information (Please print)

Patient Name: _____ DOB _____ Date _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Patient Sex ☐ Male ☐ Female

Alternative Contact _____ Telephone _____

Insurance Info – Primary/Medicare	**Secondary (Supplemental) Insurance info**
Primary Insurance _____	**Secondary Ins** _____
Policy # _____	**Policy #** _____
Group # _____	Group # _____
Policyholder's Name _____	Policyholder's Name _____

Diagnosis: (required) ☐ COPD (496) ☐ Asthma (unspecified) (493.90) ☐ Emphysema – other (492.8) ☐ Bronchitis (491.9) ☐ Pneumonia (486) ☐ Other _____

Medication: (required)	**Frequency: (required)**
☐ Albuterol 0.083% 3ml UD	☐ BID ☐ TID ☐ QID ☐ Other: _____
☐ Ipratropium 0.02% 2.5 ml UD	☐ BID ☐ TID ☐ QID ☐ Other: _____
☐ Duoneb® 3 ml UD	☐ BID ☐ TID ☐ QID ☐ Other: _____
☐ Albuterol 2.5 mg/ Iprat 0.5 mg 3 ml UD	☐ BID ☐ TID ☐ QID ☐ Other: _____
☐ *Albuterol 1.25 mg/ Iprat 0.5 mg 3 ml UD	☐ BID ☐ TID ☐ QID ☐ Other: _____
☐ *Xopenex® 1.25 mg/ Iprat 0.5 mg 3 ml UD	☐ BID ☐ TID ☐ QID ☐ Other: _____
☐ *Albut 2.5 mg/ Iprat 0.5 mg/ Budesonide 0.5 mg 3 ml UD	☐ BID ☐ TID ☐ QID ☐ Other: _____
☐ *Albuterol 2.5 mg/ Budesonide 0.5 mg 3 ml UD	☐ BID ☐ TID ☐ QID ☐ Other: _____
☐ *Albuterol 1.5 mg/ Budesonide 0.25 mg 3ml UD	☐ BID ☐ TID ☐ QID ☐ Other: _____
NEW!!! ☐ *Formoterol 12 mcg/ Budesonide 0.5 mg 3 ml UD	☐ BID ☐ TID ☐ QID ☐ Other: _____

Additional Medications:

☐ Albuterol Inhaler MDI #1 Unit	☐ BID ☐ TID ☐ QID X Other: _PRN __
☐ _____	☐ BID ☐ TID ☐ QID ☐ Other: _____
☐ _____	☐ BID ☐ TID ☐ QID ☐ Other: _____

REFILLS: 1 2 3 4 5 6 _____ **Quantity:** ☐ 1 month supply ☐ other _____

* Not available commercially. For additional combinations not listed above, please call our pharmacist at 800-345-4268. All compounding is done in the professional sterile lab on premises.

Equipment

☐ **Nebulizer required** – Please dispense
☐ **Medication only** (No equipment req-d)

Nebulizer System Serial # _____
(For pharmacy use)

Physician Name _____ **UPIN #** _____

Address _____ **License No.** _____

City _____ **DEA #** _____

State _____ **Zip** _____ **Phone** _____ **Fax** _____

Physician Signature (required) _____ **Date** _____

Important Warning: The documents accompanying this transmission contain confidential health information that is legally privileged. This information is only intended 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 regulations. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately for the destruction of these documents.

Better Living Now, Inc.
500 Wheeler Road
Hauppauge, NY 11788

Phone: 631.348.0032
Fax: 631.348.7704

1) **Instructions**
   a) **Patient**
      i) Please complete the Member section of the order from on the reverse side indicating the insurance you have that provides coverage for your respiratory medications and supplies.
      ii) Please complete the Medical History Information Requested Below.
   b) **Doctor**
      i) Please complete the patient information and doctor information sections.
      ii) Please indicate the products and medications you want supplied to the patient, with directions for use and quantity required; (**NY State requires one prescription per blank, please make copies)**
      iii) Please sign and date on the spaces provided.
2) **Some Medicare Coverage Rules that should be noted:**
   a) **If treatment regimen exceeds 4 times per day, Medicare requires a detailed explanation of the reason/s: (check all that apply)**
      i) ☐ Obstructed Airway (progressive inelasticity of the lungs) ☐ Emphysema ☐ COPD
      ii) ☐ Crackling & Congestion in the lungs ☐ Pneumonia ☐ Wheezing
      iii) ☐ Obstructed Breathing (inflammation of bronchial tubes) ☐ Bronchial Spasms ☐ Asthma
      iv) ☐ Increased Asthmatic Breathing Difficulty ☐ Shortness of breath
   b) **If treatment regimen exceeds 6 times per day**, this completed form must be accompanied by a **Letter of Medical Necessity** signed by the physician on his or her letterhead.
   c) **If you fax this document**, Medicare/insurance requirements are that you maintain the signed original in the patient's medical record for post-payment review audit purposes.

Patient Medical History Form

Dear Participant

Please fill out this form, so we can better serve you and improve our ability to protect you from any drug related issues such as drug interactions, adverse reactions, side effects and disease/ drug problems. PLEASE BE AWARE THAT NEW YORK STATE LAW REQUIRES THAT WE OBTAIN THIS INFORMATION

Patien	Acct#/SS#	Patient's ID#		Sex: M F
	Patient's Last Name.	Patient's First Name:	MI:	Rel To Member M S C
Patient Address	Address 1.	Apt#.		Date of Birth.
	City	State		Zip Code
Conditions	Do you have any health conditions? If so, please check those conditions or write in "other" ☐ **Asthma** ☐ **Diabetes** ☐ **Hypertension** ☐ **Cardiovascular Disease** ☐ **Kidney Disease** ☐ **Epilepsy** ☐ **Other:**			
Allergies	Do you have any medication allergies? If so, please check those conditions or write in "other" ☐ **Penicillin** ☐ **Sulfa** ☐ **Aspirin** ☐ **Erythromycin** ☐ **Other:**			
ther Medications	Please list ALL Medications, Over-the-counter Medicines, Vitamins, Nutritional Supplements that you are currently taking:			
Patient Sig	*Patient Signature*		*Date:*	

Rx – RESPIRATORY MEDICATIONS AND SUPPLIES

Dear Doctor,

Your patient has asked us for a Nebulizer and/or Nebulizer Medication to help with his/her breathing problems. In order for your patient to receive these products, we are asking you to fill out this prescription form and return it to us. Your help in this matter is greatly appreciated by your patient and by Jefferson Medical.

Please call us with any questions you may have at 1-800-929-9440.
Once complete, please fax this form to 1-425-962-8500 or mail it to the address at the bottom of the page.

PATIENT INFORMATION

Name: _____ Date of Birth: ____ /____ /____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Social Security#: _____
Primary Insurance Provider: _____ Insurance #: _____
Secondary Insurance Provider: _____ Insurance #: _____

PRESCRIPTION INFORMATION

Medication/Supplies
Please place [X] where applicable:

[ ] Albuterol 2.5 mg + Ipratropium Bromide (Atrovent) 0.5 mg (pre-mixed)
[ ] Albuterol 2.5 mg / 3 ml (unit dose) ... 0.083% vials
[ ] Albuterol 5.0 mg / ml (20 ml bottle) ... 0.5% Concentrated Solution
[ ] Ipratropium Bromide (Atrovent) 0.5 mg / 2.5 ml ... 0.02% (unit dose) vial
[ ] Cromolyn Sodium 20 mg / 2 ml (unit dose) vials
[ ] Mucosil (Acetylcysteine) ____ 10% vials OR ____ 20% vials
[ ] Metaproterenol (Alupent) 10 mg / 2.5 ml (unit dose) ... 0.4% vials
[ ] Metaproterenol (Alupent) 10 mg / 2.5 ml (unit dose) ... 0.6% vials
[ ] Other Medication(s): _____
[ ] Nebulizer / Compressor [ ] Peak Flow Meter [ ] Other Supplies: _____

Diagnosis
Please place [X] where applicable:

[ ] 493.0 Asthma
[ ] 277.0 Cystic Fibrosis
[ ] 493.9 Bronchial Asthma
[ ] 492.8 Emphysema
[ ] 496.0 COPD
[ ] 491.0 Chronic Bronchitis
[ ] 491.2 Chronic Obst. Bronchitis

Compounded Prescriptions
Please mark [X] the combination of medications **to be compounded in one vial – one Rx**:

[ ] Albuterol 2.5 mg [ ] Cromolyn Sodium 20 mg [ ] Ipratropium 0.5 mg

	1 puff equiv/vial	2 puff equiv/vial	Other
[ ] Beclomethasone (Vanceril).....(please check one)...	___ 100 mcg	___ 200 mcg	___ 400 mcg
[ ] Budesonide (Pulmicort) .....(please check one)...	___ 200 mcg	___ 400 mcg	___ 600 mcg
[ ] Flunisolide (Aerobid) .....(please check one)...	___ 42 mcg	___ 84 mcg	___ 252 mcg
[ ] Triamcinolone (Azmacort) .....(please check one)...	___ 250 mcg	___ 500 mcg	___ 750 mcg

Note: Non-steroid compounds are per 2.5 ml. Steroid compounds are per 3.0 ml.

Directions: ____QD ____BID ____TID ____QID **How often:** _____

Start Date: ____/____/____ **# of Refills:** 1 3 6 1 year **Length of Need: 99 Months**

[ ] Patient uses or has used an inhaler [ ] Substitutions Allowed [ ] Do Not Substitute

Patient Allergies: _____

My signature below confirms that the patient has a respiratory ailment and is / was being treated by me. All the information contained herein accurately reflects the patient's respiratory condition and the regimen that I have prescribed. I also confirm that: 1) I have seen my patient in the last six months to evaluate their ailment, and 2) the patient and/or caregiver is able to follow instructions for controlling the ailment and is able to use the supplies ordered. I also agree to maintain this signed original document in the patient's medical record and make it available for insurance and/or Medicare purposes.

Physician's Signature: _____ **Date:** ____ /____ /____

Physician's Name: _____ UPIN#: _____
Physician's Address: _____
Physician's Telephone #: _____ Physician's Fax #: _____

DOCTOR ORDER

Respiratory Medications and Supplies

For Office Use Only
☑ RENEWAL
☐ INITIAL

609657 — *Instructions:* Please fill in ALL Sections and mail or fax back to Liberty. If you have any changes, please cross out, write in correction, sign, and date it. — 57889

Patient Name: [redacted] DOB: [redacted] Order Date: 01/01/2004
Address: [redacted] Medicare #: [redacted]

Check Appropriate Diagnosis

1. ☐ 496 COPD ☐ 491.9 Chronic Bronchitis ☑ 493.[9][0] Asthma ☐ Other ~~11-24-03~~
   ☐ 492.8 Emphysema ☐ 786.4 Abnormal Fluid

Physician's Prescription: (Check ✓ all that apply)

2. 1) YES - I am prescribing a: ☐ Compressor Nebulizer ☐ Portable Ultrasonic Compressor (with battery)
   2) NO - ☑ Do not send a Compressor Nebulizer, the patient currently has one.

3. ☑ ALBUTEROL SULFATE 0.083% 3mL and IPRATROPIUM BR 0.02% 2.5mL (2 separate U/D vials)
   ☐ ALBUTEROL SULFATE 0.083% 3mL (0.5mL Albuterol 0.5%, 2.5mL N.S.) U/D
   ☐ IPRATROPIUM BR 0.02% 2.5mL U/D
   ☐ CROMOLYN SODIUM 2mL Sterile Water U/D (for Asthma, diagnosis = 493.##)
   ☐ METAPROTERENOL 0.6% 2.5 mL U/D
   ☐ METAPROTERENOL 0.4% 2.5 mL U/D
   ☐ Other * (Name & Strength of Medication)
   ☐ TRIPLE BUDESONIDE COMBO: Albuterol/Ipratropium/Budesonide 2.5mg/0.5mg/0.25mg (0.5 to 3CC W/NS) 1 U/D vial
   ☐ ALBUTEROL BUDESONIDE COMBO: Albuterol/Budesonide 2.5mg/0.25mg (0.5 to 3CC W/NS) 1 U/D vial
   ☐ IPRATROPIUM BUDESONIDE COMBO: Ipratropium/Budesonide 0.5mg/0.25mg (0.5 to 3CC W/NS) 1 U/D vial

   * The above choices are only some possible therapies and others may be clinically appropriate.

4. **Times Per Day Treatment** ☐ QD ☐ BID ☐ TID ☑ QID ☐ Q4H ☐ Other _____
   MUST check ✓ one: (Medicare does not accept "PRN")

5. **Supplies** (Check ✓)
   ☑ Non Disposable Nebulizer Tubing (one every 6 months) ☑ Non Disposable Mask
   -- OR --
   ☐ Disposable Plastic Tubing (two per month) ☐ Mask ☐ Tracheotomy Collar

6. If treatment regimen exceeds 4 times per day, Medicare requires a detailed explanation of the reason: (✓ all that apply)
   ☐ Obstructed Airway (progressive inelasticity of the lungs) ☐ Crackling & Congestion in the Lungs ☐ Pneumonia
   ☐ Obstructed Breathing (inflammation of bronchial tubes) ☐ Bronchial Spasms ☐ Wheezing
   ☐ Increased Asthmatic Breathing Difficulty ☐ Shortness of Breath ☐ Other
   If treatment regimen exceeds 6 times per day, this completed form must be accompanied by a Letter of Medical Necessity signed by the physician on his or her letterhead.

7. Medicare maximum allowed duration of need is 12 months. Duration of need [12] months or if not otherwise specified (NOS), then 12 months.

By my signature below, I authorize the use of this document by a licensed pharmacy as a dispensing prescription. I certify that the information contained herein is a true and correct verification of my verbal or written order and that my medical records support the medical need for the items prescribed. I will maintain for Medicare/Insurance requirements this signed original document in the patient's medical record file for post-payment review/audit purposes.

8. Physician Signature: [signature] Date: 11/21/03 9.

10. UPIN: [redacted]

Physician's Name and Address: [redacted]

For Office Use Only — RENEWAL
OUT: [redacted]
IN:

Liberty Home Pharmacy Corporation
P.O. Box 28001 Ft. Pierce, FL 34979
Toll Free Phone: 1-877-828-2462
Toll Free FAX: 1-888-392-0792

[redacted] [redacted]

Reliant Pharmacy

Starting Jan. 1, 2004

2ml volume (need med. frequency Δ form for smaller volume)

Albut	Iprat	Budesonide
2.5 mg	0.5 mg	0.25 mg
2.5 mg	0.5 mg	0.5 mg

- preservatives??

Albut	Iprat	Triamsinolone
2.5 mg	0.5 mg	0.2 mg
2.5 mg	0.5 mg	0.4 mg ×2

QID 2ml

Advair

2ml

Albut	Iprat
3.5 mg	0.5 mg
3.5 mg	0.75 mg
4.0 mg	0.5 mg
4.0 mg	0.75 mg
5.0 mg	0.5 mg (also in 3ml volume)
5.0 mg	0.75 mg
1.25 mg	.5 mg (Still avail 3ml vials)

Duo Neb 3ml .5mg – 3mg albuterol 5mg 3mg " 2.5mg

All new pt will get 2ml volume unless ordered by physian

2ml

1) ↓ treatment time – ↑ pt compliance
2) no change in starter dose kits
3) 1 stamp per physician → 2 combinations

[redacted] [redacted]

LINCARE

85 Tomlinson Rd, Huntingdon Valley, PA 19006
(800) 627-5334 * (215) 938-9577

PATIENT INFORMATION

Patient: _____
Address: _____
_____
Home Phone: _____ Work: _____
D.O.B. : _____ SSN# _____

Primary Insurance: _____
ID# _____ Group # _____
Secondary Insurance: _____
ID # _____ Group # _____

Diagnosis: _____

****

PRESCRIPTION

__ OXYGEN at _____ liters per minute via nasal cannula X _____ hours/day

__ NEBULIZER

__ OXIMETRY __ OVERNIGHT OXIMETRY

__ OTHER: _____

MEDICATION

__ Albuterol 2.5mg / Ipratropium 0.5mg
__ Albuterol 0.083% 3.0ml
__ Ipratropium 0.02% 2.5ml
__ Cromolyn Sodium 20mg 2.0ml

Frequency: __ BID __ TID __QID __ Other _____
Length of Need: _____

M.D. Signature: _____ Lic. # _____
Address: _____
Phone: _____
Date: _____
Comments: _____
_____

PLEASE FAX TO LINCARE at 215-938-9583

[redacted]

"Cheaper and as effective as Advair or Spireva Spin Inhalers."

AMERICAN HOMEPATIENT®

1209 N Fayetteville St., Asheboro, NC 27203
[redacted]36-625-1010 Local 336-625-1423 Fax [redacted]
800-[redacted] Toll Free [redacted]

Patient Name: _____ DOB _____ SS# _____

Address: _____ Ht _____ Wt _____

Phone: ( ) _____ Insurance(s) _____ COPD/Asthma

Physician _____ UPIN _____ Physician Phone ( ) _____

SMALL VOLUME NEBULIZER COMPRESSOR ☐ Handheld ☐ Tabletop

SOLUTIONS FOR NEBULIZER	FREQUENCY
☐ Albuterol 0.083%/3ml Unit Dose	☐ QID ☐ TID ☐ BID ☐ q4hr ☐ q6hr ☐ Other _____
☐ Albuterol 0.5% 20ml	☐ QID ☐ TID ☐ BID ☐ q4hr ☐ q6hr ☐ Other _____
☐ Albuterol 2.5mg/Ipratropium 0.5mg 3ml (compound)	☐ QID ☐ TID ☐ BID ☐ q4hr ☐ q6hr ☐ Other _____
☐ Ipratropium 0.02%/2.5ml Unit Dose	☐ QID ☐ TID ☐ BID ☐ q4hr ☐ q6hr ☐ Other _____
☐ Cromolyn 20mg/2ml Unit Dose	☐ QID ☐ TID ☐ BID ☐ q4hr ☐ q6hr ☐ Other _____
☐ Albuterol 2.5mg/Budesonide 0.25mg/Ipratropium 0.5mg/3ml (compound)	☐ QID ☐ BID ☐ Other _____
☐ Albuterol 2.5mg/Budesonide 0.5mg/Ipratropium 0.5mg/3.5ml (compound)	☐ QID ☐ BID ☐ Other _____
☐ Budesonide 0.25mg/2.5ml (compound)	☐ QID ☐ BID ☐ Other _____
☐ Budesonide 0.5mg/2.5ml (compound)	☐ QID ☐ BID ☐ Other _____
☐ Generic "Pulmicort"	☐ QID ☐ TID ☐ BID ☐ q4hr ☐ q6hr ☐ Other _____

Med Care Days (for)

REFILLS: _____ QUANTITY: 30-day supply or ☐ Other _____

OXYGEN O_2 @ _____ LPM or _____ %

for _____ (duration/frequency)

ABG or O_2 Saturation: _____

via ☐ Nasal Cannula ☐ Mask ☐ Other _____

☐ Concentrator ☐ Liquid Oxygen (LOX)

Portable System: ☐ Cylinders ☐ LOX

☐ Conserving Device: Setting _____

Duration/Frequency _____

☐ Bubble Humidifier Other: _____

PATIENT ASSESSMENT

☐ Pulse oximetry.

Perform ☐ xl ☐ Other: _____ (duration/frequency)

☐ At rest ☐ With ambulation

☐ Room air ☐ On O_2 @ _____ LPM/%

☐ Overnight Other: _____

☐

Perform ☐ xl ☐ Other: _____

CPAP THERAPY _____ cmH_2O

☐ Humidifier ☐ Non Heated

☐ Heated

Other: _____

☐ Supplemental O_2 bled in at _____

BI-LEVEL/NPPV THERAPY

IPAP _____ $cm\ H_2O$ EPAP _____ $cm\ H_2O$

Mode _____ B/U Rate _____

% I Time _____ Rise Time _____

Other: _____

Duration/frequency of use _____

☐ Supplemental O_2 bled in at _____

☐ Humidifier: ☐ Non-Heated

☐ Heated

HME

☐ Bed

☐ Lift Chair

☐ Wheelchair

☐ Other _____

SPECIAL INSTRUCTIONS

This prescription may be filled by any provider of your choice.

Diagnosis _____

I give permission to American HomePatient to act as my agent in transmitting this written prescription via fax to the provider of the patient's choice

Physician Signature (Substitution allowed) _____ Date _____ Physician Signature (Dispense as written) _____

This prescription may be filled at any pharmacy of your choice. A-1053-1A (11/08)

Oxygen, Respiratory Medication and Nocturnal Oximetry Prescription

Patient name: _____ Date of Birth _____/_____/_____

Address: _____ City: _____ Zip: _____

EQUIPMENT AND SERVICES

Concentrator: ☐ Yes ☐ No **Portable:** ☐ Yes ☐ No **Helios™ Preferred?** ☐ Yes ☐ No

Oxygen Saturation Level: _____% (or) PO_2 Level: _____ Liter(s) Per Minute (LPM): _____

Test facility: _____ Test Date: _____

Pulse system evaluation including oximetry? ☐ Yes ☐ No

Nocturnal Oximetry: ☐ Room air ☐ On O2 _____ lpm

Nebulizer: ☐ Yes ☐ No ☐ Unit dose: _____ Length of need: ☐ Lifetime ☐ Other: _____

COMMONLY PRESCRIBED NEBULIZER PRODUCTS:

___ALBUTEROL 2.5 MG/1 ML *AND* IPRATROPIUM 0.5MG/2.5 ML (SEPARATE VIALS 3.5 ML TOTAL VOLUME)
___ALBUTEROL 0.083% (2.5 MG/3 ML) ___IPRATROPIUM 0.02% (0.5 MG/2.5 ML) ___CROMOLYN NA 20MG/2 ML
___ALBUTEROL 2.5MG + TRIAMCINOLONE 0.4MG (3 ML VIALS)
___ALBUTEROL 2.5MG + IPRATROPIUM 0.5 MG + TRIAMCINOLONE 0.4 MG (3 ML VIALS)
___ALBUTEROL 2.5 MG + IPRATROPIUM 1 MG + TRIAMCINOLONE 0.4 MG (3 ML VIALS)
___ALBUTEROL 2.5 MG + IPRATROPIUM 0.5 MG + DEXAMETHAZONE 0.4 MG (3 ML VIALS)
___ALBUTEROL 3 MG + IPRATROPIUM 0.5 MG (3.1 ML VIALS)
___ALBUTEROL 2.5 MG + BUDESONIDE 500 MCG (3 ML VIALS)
___ALBUTEROL 2.5 MG + IPRATROPIUM 0.5 MG + BUDESONIDE 400 MCG (3 ML VIALS)
___XOPENEX 1.25 MG/3 ML

CUSTOM MIX REQUIRED: *Combination of:* _____

CURRENT BULK PRODUCTS AVAILABLE:

ALBUTEROL BETAMETHASONE BUDESONIDE IPRATROPIUM DEXAMETHASONE TRIAMCINOLONE

SIG: ☐ BID ☐ TID ☐ QID ☐ Q4H ☐ 4 - 5 times/day ☐ Other _____

Length of need: ☐ *12 Months* ☐ *Other:* _____ *Quantity of vials:* _____

Diagnosis: ☐ COPD ☐ Emphysema ☐ Chronic Bronchitis ☐ Asthma ☐ Other _____

Medical necessity: the ability to breathe is severely impaired (CMS requires consideration of using a metered dose inhaler, with and without a reservoir or spacer device, and determination that it is insufficient for the administration of inhalation drugs).
CMS requires us to retain an original physician signature on file.

Physician name: _____ (please print)

Physician signature: _____ Date: _____/_____/_____

Physician DEA _____ UPIN _____

[illegible] Ph: [illegible] (541) 245 2400 - Fax: (541) 245 2470