Northeast Medical Products, Inc

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An Innova Medical Group Company

INNOVA MEDICAL PRODUCTS

NEBULIZER PRESCRIPTION FORM

Patient Demographics:

Patient Name _____

Address _____

Email _____

Phone _____ **Alt Phone** _____

DOB _____ **Height** _____ **Weight** _____

Alternate Contact Name _____ **Relationship** _____ **Phone** _____

Please check all that apply:

- ☐ a. It is reasonable and necessary to administer albuterol, arformoterol, budesonide, cromolyn, formoterol, ipratropium, levalbuterol or metaproterenol for the management of obstructive pulmonary disease.
- ☐ b. It is reasonable and necessary to administer dornase alpha to a beneficiary with cystic fibrosis.
- ☐ c. It is reasonable and necessary to administer tobramycin to a beneficiary with cystic fibrosis or bronchiectasis.
- ☐ d. It is reasonable and necessary to administer pentamidine to a beneficiary with HIV, pneumocystosis, or complications of organ transplants.
- ☐ e. It is reasonable and necessary to administer acetylcysteine for persistent thick or tenacious pulmonary secretions.

Nebulizer Compressor Information – Based on the above information, the following items are needed by this patient for the stated length of need:

Item – Description (Please check applicable):

- ☐ Nebulizer Compressor with Tubing & Mouthpiece (E0570)
- ☐ Adult Nebulizer Mask
- ☐ Pediatric Nebulizer Mask
- ☐ Replacement Tubing and Mouthpiece _____ Number of Refills

ICD-10 Code(s) _____

Length of Need _____

PLEASE SUPPLY A COPY OF THE CLINICAL NOTES FROM THE FACE-TO-FACE VISIT
(ALL CLINICAL NOTES MUST BE EITHER ELECTRONICALLY SIGNED OR HAVE A WET SIGNATURE)

Prescribing Physician's Name _____ NPI _____

Address _____

Phone _____ Fax _____

_____ _____

Physician Signature Date