



Respiratory Medications and Supplies

Instructions: Please fill in ALL sections and mail or fax along with a copy of patient's health benefit card to BLN. If you have any changes, please cross out; write in correction, sign, and date. ( NY State law requires one prescription per form)

Member information section including Insurance Plan, Member's Insured ID#, Sex (M/F), Member's Last Name, Member's First Name, MI, Date of Birth (DOB), Acct#/SS#, Patient's ID#, Patient's Last Name, Patient's First Name, MI, Rel To Member (M/S/C).

Diagnosis section: Check Appropriate Diagnosis: 0 496. COPD 0 491.9 Chronic Bronchitis 0 493.9 Asthma 0 492.8 Emphysema 0 786.4 Abnormal Fluid 0 Other \_\_\_\_\_ 0 Prognosis \_\_\_\_\_

Nebulizer & Supplies section: Does patient need a Nebulizer? Please provide Doctor Order as follows: (Check all that apply) 0 YES - I am prescribing a: 0 Compressor Nebulizer (BLN Choice-SportNeb, PulmoAide, etc.) 0 NO - Do not send a Compressor Nebulizer the patient currently has one. Other Needed Supplies: (A7003 & A7005 include: the lid, jar, baffles, tubing, t-piece and mouthpiece) 0 (A7003) Disposable supplies kit 0 (A7005) Non-disposable supplies kit 0 (A7006) Kit plus filter 0 Mask Tracheostomy Collar

Rx - Doctor's Prescription - Rx (NYS requires 1 item per rx order form)

Table with 4 columns: Check, Medication Name, Directions (Sig:), Other, Quantity. Rows include Albuterol Sulfate 0.083% 3ml and Ipratropium Bromide 0.02% 2.5ml (2 separate u/d vials), Albuterol Sulfate 0.083% 3ml, Cromolyn Sodium 2ml Sterile Water, Metaproterenol 0.6% 2.5mL U/D, Acetylcysteine 10% 4mL U/D (for abnormal fluid diagnosis 780.4), Acetylcysteine 20% 4mL U/D (for abnormal fluid diagnosis).

Steroid Products

Table with 4 columns: Medication Name, Directions (Sig:), Other, Quantity. Rows include Triple Dex. Combo: Albuterol, Ipratropium and Dexamethasone 2.5mg/0.5mg (QS TO 3CC ) 1 U/D VIAL, Albuterol Sulfate 0.083% and Dexamethasone 0.2mg, Triple Triam. Combo: Albuterol, Ipratropium and Triamcinolone 2.5/0.5mg, Albuterol 0.083% 3ml and Triamcinolone 0.5mg (2 Separate U/D Vials), Other.

Could the patient obtain an equivalent therapy using Metered Dose Inhalers? 0 Yes 0 No, Explain:

Doctor's Information section: Dr's Stamp, Dr's Name, Dr's Address, Dr's City, State Zip, Dr's Phone#, Dr's UPIN#, Dr's Signature, Dr's License#, Date of Visit, Dr's DEA#. Includes text: THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES 'd a w' IN THE BOX BELOW. Dispense As Written.

\*\*\* NY State requires one item per rx order form\*\*\* \*\*\*Please see other side for additional instructions\*\*\*



# Doctor Order Form – **Respiratory** Instructions

185 Oser Ave.  
Hauppauge, NY 11788  
Phone: 1.800.854.5729  
Fax: 1.877.262.2183

[www.BetterLivingNow.com](http://www.BetterLivingNow.com)

## 1) Instructions

### a) Patient

- i) Please complete the Member section of the order form 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.

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