

NASAL MEDICATION ORDER FORM

Phone: 855-876-3060 Fax: 866-893-9320



1. Patient Information

Patient: _____ DOB: ____/____/____
 Age: _____ M ☐ F ☐ Tel: Home (____) _____
 Work (____) _____ Cell (____) _____
 Address: _____
 City: _____ ST: _____ Zip: _____
 Medical Ins. (or fax copy of card): _____
 ID#: _____ Group#: _____
 Ins Tel#: (____) _____ Medication Allergies: _____

2. Diagnosis

- ☐ J32.9 CRS, Unspecified
☐ J30.9 Allergic Rhinitis, Unspecified
☐ J01.90 Acute Sinusitis, Unspecified
☐ J32.0 Chronic Sinusitis, Maxillary
☐ J32.1 CRS, Frontal
☐ J32.2 Chronic Sinusitis, Ethmoidal
☐ J32.3 CRS, Sphenoidal
☐ J01.40 Acute Sinusitis, Pansinusitis
☐ J32.4 CRS, Pansinusitis
☐ B49 Mycoses, Unspecified
☐ Other _____

3. Prescription most often ordered by physicians

Check box indicates BID X 30 days unless alternate directions are marked.

	Refills	ALTERNATE	
		SIG	DAYS
<input type="checkbox"/> Vancomycin (200 mg) + Betamethasone (0.5 mg) + Tobramycin (100 mg)			
<input type="checkbox"/> Tobramycin (100mg) + Betamethasone (0.5 mg) + Mupirocin (5 mg)			
<input type="checkbox"/> Levofloxacin (100 mg) + Betamethasone (0.5 mg)			
<input type="checkbox"/> Tobramycin (100 mg) + Betamethasone (0.5 mg) + Itraconazole (40 mg)			
<input type="checkbox"/> Tobramycin (100 mg) + Betamethasone (0.5 mg) + Amphotericin B (5 mg)			
<input type="checkbox"/> Levofloxacin (100 mg) + Betamethasone (0.5 mg) + Amphotericin B (5 mg)			
<input type="checkbox"/> Tobramycin (100 mg) + Betamethasone (0.5 mg) + Clindamycin (150 mg)			
<input type="checkbox"/> Itraconazole (40 mg) + Betamethasone (0.5 mg) + Clindamycin (150 mg)			
<input type="checkbox"/> Levofloxacin (100 mg) + Betamethasone (0.5 mg) + Clindamycin (150 mg)			

Single Medications BID X 30 days	Refills	ALTERNATE		Single Medications BID X 30 days	Refills	ALTERNATE	
		SIG	DAYS			SIG	DAYS
<input type="checkbox"/> Acetylcysteine (200 mg)				<input type="checkbox"/> Itraconazole (40 mg)			
<input type="checkbox"/> Amphotericin B (5 mg)				<input type="checkbox"/> Levofloxacin (100 mg)			
<input type="checkbox"/> Betamethasone (0.5mg)				<input type="checkbox"/> Mupirocin (5 mg) -Atomizer Dose			
<input type="checkbox"/> Budesonide (0.6 mg)				<input type="checkbox"/> Mupirocin (15 mg) -Rinse Dose			
<input type="checkbox"/> Gentamicin (80 mg)				<input type="checkbox"/> Nystatin (50,000 units)			
<input type="checkbox"/> EDTA (15 mg) (Chelating Agent)				<input type="checkbox"/> Tobramycin (100 mg)			
<input type="checkbox"/> Other				<input type="checkbox"/> Vancomycin (200 mg)			

4. Delivery Devices

Atomized Nasal Sinus Therapy



☐ RhinoClear Sprint™ Atomizer

Atomize medication into both nostrils BID x 30 days

Alternate Dosing: _____ X _____ Days

☐ NASONEB™ NASAL NEBULIZER



☐ NasoNeb® Nasal Nebulizer

Use as directed

Alternate Dosing: _____ X _____ Days

Medicated Sinus Rinse Therapy:



☐ NeilMed® Saline Rinse

Add medication to 240ml of saline. Rinse each nostril with 120ml of medicated saline BID x 30 days.

Alternate Dosing: _____ X _____ Days

☐ Other: _____

5. Physician Verification

I have reviewed my patient's medical record and determined the medication(s) / supplies ordered are medically necessary. I verify I have examined and diagnosed the patient as indicated above. I will comply with state and federal documentation requirements by retaining a copy of this prescription in the patient's medical record. The prescription is to be dispensed as written unless otherwise instructed by me.

Signature: _____ Date: _____

Physician: _____ NPI #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Fax: _____

FAX FORM TO: (866) 893-9320

IMPORTANT: Please fax insurance card. Your patient will be called promptly.