

Universal Fax Referral / Prescription Form

For a list of select home health care pharmacies, visit <http://hhc.brovana.com>

Home Health Care Provider _____ Fax Number _____

PATIENT INFORMATION (Please print)

Patient Name _____ Phone _____ Alt Phone _____

Address _____ City _____ State _____ ZIP _____

Language English Spanish Other _____ Sex: M F Date of Birth: _____

Parent or guardian name if patient is a minor _____

PHYSICIAN INFORMATION

Physician Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____

Fax _____

UPIN / NPI# _____ DEA# _____

INSURANCE INFORMATION Complete, or fax a copy of the front and back of the patient's insurance card or face sheet with this form.

Medicare Medicaid ID# _____

Other Insurance _____

ID# _____ Group# _____

Phone _____

Policyholder's Name (if other than patient) _____

NARRATIVE ICD-9 DIAGNOSIS (Check one)

- | | |
|--|---|
| <input type="checkbox"/> 491.0 Simple chronic bronchitis | <input type="checkbox"/> 491.90 Unspecified chronic bronchitis |
| <input type="checkbox"/> 491.10 Mucopurulent chronic bronchitis | |
| <input type="checkbox"/> 491.20 Obstructive chronic bronchitis, without exacerbation | <input type="checkbox"/> 492.0 Emphysematous bleb |
| <input type="checkbox"/> 491.21 With (acute) exacerbation | <input type="checkbox"/> 492.80 Other emphysema |
| <input type="checkbox"/> 491.22 With acute bronchitis | <input type="checkbox"/> 496 Chronic airway obstruction, not elsewhere classified |
| <input type="checkbox"/> 491.80 Other chronic bronchitis | <input type="checkbox"/> Other _____ |

Other Insurance _____

ID# _____ Group# _____

Phone _____

Policyholder's Name (if other than patient) _____

MEDICATION: (required)

FREQUENCY: (required)

LENGTH OF PRESCRIPTION

Start Date _____

Brovana™ (arformoterol tartrate) 15 mcg/2 mL*

BID

Other _____

12 months or other _____

Xopenex® (levalbuterol HCl) 1.25 mg/3 mL

QD

BID

TID

QID

Other _____

12 months or other _____

Xopenex HFA® (levalbuterol tartrate)

QD

BID

TID

QID

Other _____

12 months or other _____

Albuterol 2.5 mg/3 mL

QD

BID

TID

QID

Other _____

12 months or other _____

Ipratropium bromide 500 mcg/2.5 mL

BID

TID

QID

Other _____

12 months or other _____

Other _____

BID

TID

QID

Other _____

12 months or other _____

Dispensing Quantity: 1-month supply provided unless noted _____

Refills: 12 months or Other _____ Patient was sent home with starter doses Yes No

Equipment prescribed: Pharmacy to deliver nebulizer system to patient (includes compressor, video (if needed), 2 disposable neb kits, and filters)

Medication only; patient has nebulizer

Other _____

Statement of Medical Necessity

XOPENEX 1.25 mg BROVANA
(Please check one)

Comments: _____

FOR BROVANA ONLY: The patient has a documented history of routine use of at least three times a day of levalbuterol inhalation solution or at least four doses per day of another nebulized short-acting beta-adrenergic agonist inhalation solution (e.g., albuterol, metaproterenol).

*Medicare Part B coverage allows for a monthly prescription of 2 doses of BROVANA per day. In addition, Medicare Part B also allows for a prescription of 31 doses of a nebulized short-acting beta-agonist (SABA) per month as rescue/supplemental medication when BROVANA is prescribed. Both BROVANA (2/day) and the nebulized short-acting beta-agonist (31/month) should be clearly indicated on the Universal Fax Referral/Prescription Form.

Note that this coverage determination does not affect metered-dose inhaler (MDI) SABAs (Medicare Part D benefit) or nebulized ipratropium bromide (Medicare Part B benefit).

Date (required) _____ Physician Signature (required) _____

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