Foundation Care
An AcariaHealth Solution

Date Shipment Needed: ____________.

Phone: 877.291.1122 • Fax: 877.291.1155

INHALED ANTIFUNGALS FOR RECONSTITUTION REFERRAL FORM

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:	Phone:		❑ Please attach demographic information		

PRESCRIBER INFORMATION			
Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:	
Address:		City: State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: (ICD-10 Code & Description) ❑ E84.0CF w/ Pul Man. ❑B44.1 Pul Aspergillosis ____________________

- Has patient been treated *previously* for this condition? ❑Yes ❑No Medication(s): ____________________
- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): ____________________
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If yes: ____________________
- How long should patient wait before starting the new medication? ____________________
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): ____________________

INSURANCE INFORMATION

❑ **Please attach front and back of patient's insurance card (medical and prescription)**

PRESCRIPTION INFORMATION (will dispense medication and supplies with standard directions, frequency, duration, quantity, and refills (marked in bold) unless otherwise indicated).

Equipment (Select handset type for dispensing if necessary):
❑**eRapid™ Nebulizer** ❑**PARI LC PLUS® Nebulizer** (**QTY. 1, use as directed with nebulized medications, refill 11** or _____.)

Filter Supplies: (Select filter supplies for dispensing if necessary):
❑**PARI Filter/ Valve set** (**QTY. 1, use as directed with nebulized medications, refill 11** or _____.) ❑**PARI Filter Pads** (**QTY. 30** or _____, **use 1 pad as directed with each dose of nebulized medication, refill 11** or _____.)

Supplies: Syringes (any size appropriate) (**QTY. 1 month** or _____, **use as directed**, **refills 6** or _____.) **Alcohol Swabs (Qty 1 month)** **Sharps Container (Qty 1)**

MEDICATION (To Be Reconstituted And Inhaled Via Nebulizer By Mouth)	MIXING DIRECTIONS
❑ **Amphotericin B *(conventional)* 25mg/4mL** *Dispense Amphotericin B (conventional)50mg powder vial for inj. and sterile water (10mL) vial for inj.*	**Reconstitute 1 vial amphotericin B (conventional) 50mg with 8mL sterile water and nebulize 4mL (25mg).**
❑ **Amphotericin B *(conventional)* 50mg/4mL** *Dispense Amphotericin B (conventional)50mg powder vial for inj. and sterile water (10mL) vial for inj*	**Reconstitute 1 vial amphotericin B (conventional) 50mg with 4mL sterile water and nebulize 4mL (50mg).**
❑**Other (Include drug, diluent and final concentration)**	❑**Other (Include mixing directions)**

FREQUENCY	DURATION	QUANTITY	REFILLS
Daily or _________	**Every Month** or _______	**1 Month** or ______	**6** or _______

MEDICATION (To Be Reconstituted And Inhaled Via Nebulizer By Mouth)	MIXING DIRECTIONS
❑ **Amphotericin B *(liposomal)* 25mg/4mL** *Dispense Amphotericin B (liposomal) 50mg powder vial for inj. and sterile water (10mL) vial for inj.*	**Reconstitute 1 vial amphotericin B (liposomal) 50mg with 8mL sterile water and nebulize 4mL (25mg).**
❑ **Amphotericin B *(liposomal)* 50mg/4mL** *Dispense Amphotericin B (liposomal) 50mg powder vial for inj. and sterile water (10mL)) vial for inj*	**Reconstitute 1 vial amphotericin B (liposomal) 50mg with 4mL sterile water and nebulize 4mL (50mg).**
❑**Other (Include drug, diluent and final concentration)**	❑**Other (Include mixing directions)**

FREQUENCY	DURATION	QUANTITY	REFILLS
Three Times Weekly or _________	**Every Month** or _______	**1 Month** or ______	**6** or _______

Brand is Medically Necessary (Prescriber is required to handwrite):____________________

Prescriber's Signature: ________________________ ❑ DAW (Dispense as Written) **Date:** ____________

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through Foundation Care, this prescription shall be forwarded to an eligible pharmacy.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document. Please direct all verification or notification to Foundation Care or any of its subsidiaries using the contact information provided on this coversheet.

Rev. 4.27..22