



Phone: 800-818-6486 ♦ Fax: 800-818-6490 ♦ www.psipharmacy.com

Fax Prescription Form

Please complete the prescription on the following page or attach prescriptions and return by fax to PSI, along with this completed cover sheet. PSI's fax number is **800-818-6490**.

If you would like to order pre-populated prescription forms, please contact PSI by phone or fax.

PSI will promptly contact the person listed below with coverage criteria and patient status.

Office Contact: _____

Preferred Method of Contact: ☐ Phone: _____ ☐ Fax: _____ ☐ E-mail: _____

Demographics do not need to be completed if a demographic sheet is to follow

Diagnosis (must be filled in with all relevant codes): _____

Patient: _____ Wt: _____ DOB: _____ Last 4 digits of SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell #: _____ Home #: _____ Gender: ☐ M ☐ F

To expedite the benefits investigation, please attach:

☐ **Enlarged copy of the front and back of the insurance card** ☐ **Chart notes** ☐ **Labs** ☐ **Supporting clinical documentation**

Insurance: _____ **Pharmacy Help Desk Phone:** _____ **ID Number:** _____
Group Number: _____ **Rx Group:** _____ **Rx BIN:** _____ **Rx PCN:** _____

- ☐ Rx: **Cayston® (75 mg) and Altera® Hand Held Device** Sig: Nebulize 1 vial TID **Disp 28 day supply with handset** Refill: _____
(Altera® Nebulizer System will be provided—System Includes Controller, 1 Altera® Handset, Nebulizer Connection Cord, AC Power Supply, 4 AA Batteries).
- ☐ Rx: **Colistimethate 150 mg vials** Dispense all necessary supplies for preparation and administration. **Disp 30 day supply** Refill: _____
Sig: Swirl to mix and after dissolution, withdraw entire volume and nebulize BID _____ q other month _____ q month
☐ Mix vial with _____ mL of Sterile Water ☐ Mix vial with _____ mL each of Sterile Water and Normal Saline
☐ **LC® Sprint Nebulizer** ☐ **LC® Plus Nebulizer** ☐ **Compressor** Dispense 1 unit and replace nebulizer every 6 months.
- ☐ Rx: **Bethkis® 300 mg/4 mL ampules** Sig: Nebulize one ampule BID _____ q other month _____ q month **Disp 56 ampules (one box)** Refill: _____
☐ **LC® Plus Nebulizer/PARI Vios® PRO** Dispense 1 unit and replace nebulizer every 6 months.
- ☐ Rx: **Kitabis™ Pak 300 mg ampules** Sig: Nebulize one ampule BID _____ q other month _____ q month **Disp 56 ampules (one box)** Refill: _____
☐ **LC® Plus Nebulizer/Pulmo-Aide Compressor** (Only FDA approved device combination) Dispense 1 unit.
- ☐ Rx: **Tobramycin 300 mg/5 mL ampules** Sig: Nebulize one ampule BID _____ q other month _____ q month **Disp 56 ampules (one box)** Refill: _____
☐ **LC® Plus Nebulizer/Pulmo-Aide Compressor** (Only FDA approved device combination) Dispense 1 unit and replace nebulizer every 6 months.
- ☐ Rx: **TOBI® 300 mg ampules** Sig: Nebulize one ampule BID _____ q other month _____ q month **Disp 56 ampules (one box)** Refill: _____
☐ **LC® Plus Nebulizer/Pulmo-Aide Compressor** (Only FDA approved device combination) Dispense 1 unit and replace nebulizer every 6 months.
- ☐ Rx: **TOBI® Podhaler™** **Disp 28 day supply** Refill: _____
Sig: Inhale the contents of four 28 mg TOBI® Podhaler™ capsules BID using Podhaler™ device
- ☐ Rx: **Pulmozyme® Inhalation solution 2.5 mg** Sig: Nebulize ☐ Daily OR ☐ BID **Disp 30 day supply** Refill: _____
☐ **LC Plus® Nebulizer/PARI Vios®** ☐ **Sidestream®/Mobilaire™** ☐ **Sidestream®/Porta-Neb®** ☐ **Hudson T Up-Draft II®/Pulmo-Aide®**
☐ **Marquest Acorn II®/Pulmo-Aide®** (Only FDA approved device combinations) Dispense 1 unit with all necessary supplies & replace nebulizer every 6 months.
- ☐ Rx: **Hyper Sal® 7% 4 mL (Box of 60)** Sig: Nebulize BID before antibiotic therapy **Disp 30 day supply** Refill: _____
- ☐ Rx: **Hyper Sal® 3.5% 4 mL (Box of 60)** Sig: Nebulize BID before antibiotic therapy **Disp 30 day supply** Refill: _____
- ☐ Rx: **Albuterol Inhalation solution** ☐ **2.5 mg/3 mL (0.083%)** ☐ **1.25 mg/3 mL (0.042%)** **Disp 30 day supply** Refill: _____
Sig: Nebulize 1 vial _____ times daily (or every _____ hours)
- ☐ Rx: **Albuterol MDI** Sig: _____ **Disp 30 day supply** Refill: _____
- ☐ Rx: **Montelukast Sodium** ☐ **4 mg chewable** ☐ **5 mg chewable** ☐ **10 mg tablet** **Disp 30 day supply** Refill: _____
Sig: Take one tablet by mouth once daily
- ☐ Rx: **Creon®** ☐ **3,000** ☐ **6,000** ☐ **12,000** ☐ **24,000** ☐ **36,000** **Disp** _____ Refill: _____
Sig: _____ Capsules with meals _____ Capsules with snacks _____ Capsules with tube feeds
- ☐ Rx: **Zenpep®** ☐ **3,000** ☐ **5,000** ☐ **10,000** ☐ **15,000** ☐ **20,000** ☐ **25,000** **Disp** _____ Refill: _____
Sig: _____ Capsules with meals _____ Capsules with snacks _____ Capsules with tube feeds
- ☐ Rx: **Pertzye®** ☐ **8,000** ☐ **16,000** **Disp** _____ Refill: _____
Sig: _____ Capsules with meals _____ Capsules with snacks _____ Capsules with tube feeds
- ☐ Rx: **Other Enzyme:** _____ **Disp** _____ Refill: _____
Sig: _____ Capsules with meals _____ Capsules with snacks _____ Capsules with tube feeds
- ☐ Rx: **Complete Formulation Vitamins** ☐ **Softgels** ☐ **Chewables** ☐ **Drops** ☐ **D3000** Sig: _____ **Disp 30 day supply** Refill: _____
- ☐ Rx: **Other Medication:** _____ Sig: _____ **Disp 30 day supply** Refill: _____
- ☐ Rx: **Other Medication:** _____ Sig: _____ **Disp 30 day supply** Refill: _____

Practice Name: _____

Provider Name: _____ **License #:** _____ **DEA #:** _____ **NPI #:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Office Contact: _____ **Phone:** _____ **Fax:** _____ **Email:** _____

PRESCRIBER SIGNATURE: _____ **DATE:** _____