# Nebulizer Request Form

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>Member Name:</td>
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<tr>
<td>Prescriber Name:</td>
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<td>DOB:</td>
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<td>NPI:</td>
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<td>IEHP ID Number:</td>
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<td>Office Phone Number:</td>
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<td>Phone Number:</td>
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<td>Office Fax Number:</td>
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<td>Address:</td>
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<td>Office Address:</td>
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## In-Network Pharmacy Request:

**Nebulizer Device #1**  
Sig: Use as directed

**Please select ONE of the following nebulizer devices:**

- Devilbiss Pulmomate Compressor #1  
  NDC #16958-0374-72
- Devilbiss Pulmo-Aide Compressor-Nebulizer #1  
  NDC # 16958-0461-99
- Devilbiss Pulmo-Aide Compressor #1  
  NDC #16958-0462-31
- Devilbiss Pulmo-Aide Compact Compressor #1  
  NDC # 16958-0684-58
- Devilbiss Compact Compressor #1  
  NDC #16958-0687-81
- Devilbiss Pulmo-Aide Compressor #1  
  NDC # 16958-0688-64
- Devilbiss Sunrise Compressor-Nebulizer #1  
  NDC #16958-0768-88
- Other ______________________________

## In-Network MAIL ORDER Pharmacy Request:

**PREVEON HEALTH**  
Phone# (909) 693-3376  Fax# (909) 494-5582

Preveon Health provides a mail order option that includes the nebulizer device along with a starter supply of medications. Please note that the starter pack is ONLY for a **2-WEEK SUPPLY**. Any subsequent refills must be filled at patient’s preferred pharmacy.

**Nebulizer Device #1**  
Sig: Use as directed

- Devilbiss Pulmo-Aide Compact Compressor  
  NDC # 16958-0684-58

**Nebulizer Accessories:**  
Sig: Use as directed

- □ Mask, Disposable Tubing Kit, and Filter #1 each + _____ Refills

*Note: Accessories are only compatible with Devilbiss models.*

**Medication Starter Pack Options:**

- □ Albuterol 0.083% #180ml (60 vials) + 0 Refills  
  Sig: Use 1 vial via nebulizer QID PRN  
  Other sig: __________________________

- □ Ipratropium 0.02% #150ml (60 vials) + 0 Refills  
  Sig: Use 1 vial via nebulizer QID PRN  
  Other sig: __________________________

- □ Budesonide #60ml (30 vials) + 0 Refills  
  □ 0.25mg  □ 0.5mg  □ 1mg  
  Sig: Use 1 vial via nebulizer BID  
  Other sig: __________________________

Prescriber Signature:  
Date: