INLAND EMPIRE HEALTH PLAN

Nebulizer Request Form

Member Name:	**Prescriber Name:**
DOB:	**NPI:**
IEHP ID Number:	**Office Phone Number:**
Phone Number:	**Office Fax Number:**
Address:	**Office Address:**

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:**