PRESCRIPTION

LOXASPERSE ORDER FORM

PATIENT INFORMATION

FIRST NAME: LAST NAME: DATE of BIRTH (Month / Day)

_____/_____

PRIMARY PHONE #: ◯ CELL ◯ HOME ◯ WORK SECONDARY PHONE #: ◯ CELL ◯ HOME ◯ WORK

ADDRESS: CITY, STATE, ZIP: ALLERGIES:

COMMON LOXASPERSE CAP

☐ Itraconazole	Strength _____	◯ 30	◯ 60	◯ 90 or _____
☐ Levofloxacin	Strength _____	◯ 30	◯ 60	◯ 90 or _____
☐ Tobramycin	Strength _____	◯ 30	◯ 60	◯ 90 or _____
☐ Vancomycin	Strength _____	◯ 30	◯ 60	◯ 90 or _____

COMMON COMBINATIONS

☐ Levo / Beta	Strength _____	◯ 30	◯ 60	◯ 90 or _____
☐ Tobra / Beta / Ampho B	Strength _____	◯ 30	◯ 60	◯ 90 or _____
☐ Tobra / Beta / Clinda	Strength _____	◯ 30	◯ 60	◯ 90 or _____
☐ Tobra / Beta / Mupir	Strength _____	◯ 30	◯ 60	◯ 90 or _____
☐ Vanco / Beta	Strength _____	◯ 30	◯ 60	◯ 90 or _____

Other

☐ Mupirocin Oint Nasal Spray	22gm / 45ml	◯ 45 or _____
☐ Nebulizer		Indicate _____
☐ Neilmed		Indicate _____
☐ Sodium Chloride Ampule		Indicate _____

Commercial

☐ Budesonide Inhal	0.5 mg / 2 ml	◯ 30 or _____
☐ Gentamycin Inj	80 mg / 2 ml	◯ 25 or _____
☐ Tobramycin Inj	80 mg / 2 ml	◯ 25 or _____

Refills: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ PRN ◯ NR SIG:_____

WRITE PRESCRIPTION / ADDITIONAL COMMENTS

DOCTOR PHONE NPI # DEA #

OFFICE MANAGER PHONE OFFICE FAX OFFICE Email

SIGNATURE DATE (Month / Day / Year)

_____/_____/_____