

A&B MEDICAL SUPPLIES, LLC

BA

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PRESCRIPTION**ATTENTION: Protected by Federal Law!**

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Patient Name: _____

Phone Number: _____

Address: _____

City/State/Zip: _____

Date Of Birth: _____

Male or Female: _____

Medicare

Primary Insurance: _____

Policy Number: _____

Secondary Insurance _____

Policy Number _____

ICD-9 Code _____

Diagnosis _____

Medication:**Frequency:**

			Q6	QID	TID	BID	PRN	other	Max/24 Hrs
Xopenex 1.25mg / 3ml (unit dose)	# Refills: <input type="text"/>	Quantity: <input type="text"/>	# Days: <input type="text"/>						
Ipratropium Bromide 0.5mg. (unit dose)	# Refills: <input type="text"/>	Quantity: <input type="text"/>	# Days: <input type="text"/>						
Formoterol 12mcg. compound (unit dose)	# Refills: <input type="text"/>	Quantity: <input type="text"/>	# Days: <input type="text"/>						
Pulmicort 0.25mg (unit dose)	# Refills: <input type="text"/>	Quantity: <input type="text"/>	# Days: <input type="text"/>						
<input type="checkbox"/> Nebulizer Compressor	<input type="checkbox"/> Disposable Nebulizer Kit	<input type="checkbox"/> Meds Only	<input type="checkbox"/> Other						

X

Date: _____

UPIN Number: _____

X

NPI Number: _____

Physician Name: (please print) _____

Phone Number: _____

X

Physician Signature: (substitution permitted) _____

Physician Signature: (dispense as written) _____

MISSOURI PHARMACY REGULATIONS DO NOT PERMIT STAMPED SIGNATURE

Please Fax Order To Toll Free: 1-866-542-4605

Drug Allergies: _____