AUBURN PHARMACY

"Caring for the health of you and your community"

Detailed Written Physician Order

CPAP Supplies

Patient name: _____ **HICN#** _____

Address: _____ **Phone:** _____

_____ **DOB:** _____

Date of Order: ____/____/____ **Start Date:** ____/____/____

Length of need: _____ (1-99 months) (99 = Lifetime)

Diagnosis (List all): (1) _____ (2) _____ (3) _____ (4) _____

Detailed description of Equipment and/or supplies:
Dispense Supplies up to:

A7030	Full Face Mask	1 per 3 months
A7034	Nasal Mask	1 per 3 months
A7035	Headgear	1 per 6 months
A7037	Tubing	1 per 3 months
A4604	Heated Tubing	1 per 3 months
A7031	Replacement Full-Face Cushion	1 per 1 month
A7032	Replacement Nasal Cushion	2 per 1 month
A7033	Replacement Nasal Pillows	2 per 1 month
A7036	Chinstrap	1 per 6 months
A7038	Disposable Filter	2 per 1 month
A7039	Non-Disposable Filter	1 per 6 months
A7046	Replacement Water Chamber	1 per 6 months

Mask/Pillow - Type/size: _____ Patient preference if not noted.

Provider: AuBurn Pharmacy **Physician:** _____

Address: _____ **Address:** _____

_____ _____

Phone: _____ **Phone:** _____

NPI#: _____ **NPI#:** _____

Physician Signature: _____ **Date:** _____