Spiro PD 2.0 Referral Form

Phone: 877-385-0535 Fax: 877-326-2856

Patient Demographics

Name: _____ ☐M ☐F
DOB: _____ SS#: _____
Phone: _____ 2nd Phone: _____
Email: _____
Address: _____
City: _____ State: _____ Zip: _____
Primary language, if other than English: _____

Authorized alternate contact information
Name/relation: _____
Phone: _____ Email: _____

Provider Information

Prescriber: _____
_____
Phone: _____ Fax: _____
Facility/Clinic Name:_____
Address: _____
_____
NPI: _____ Office contact: _____

Training by: ☐ Prescriber's office ☐ PMD Healthcare ☐ Not needed

****Please fax a copy (front and back) of the patient's insurance card(s) as well as any relevant clinical notes/documents****

Clinical Information

Diagnosis: _____ **ICD-10 Code:** _____
Clinical Information/Comments: _____
_____
_____

Clinical Support*

☐Patient to be enrolled in OptiMed's monitoring services and specialty pharmacy medication management*

Device(s) Ordered

☐ **Spiro PD 2.0 Personal Spirometer** – personal digital spirometer, mouthpiece, stand, and charging cord (Quantity #1)

*Clinical support service includes monitoring of lung function through the PMD portal in conjunction with the provision of specialty pharmacy medication management (clinical pharmacist review, proactive refill management and adherence support, and insurance benefit investigation, financial assistance, compliance and adherence packaging as needed).

Please include a Statement of Medical Necessity

Provider Signature X	**Date**
Printed Name	

My signature for this prescription also authorizes OptiMed Health Partners and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process.