℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
Non-Invasive Ventilation RX/DWO

Date of Last Provider Visit__________________

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
713 Northway Dr Anchorage, AK 99508 NSC#: 1267160001 Phone: (907) 274-0770 Fax: (907) 274-0773	**(_____) _______ - ___________ HIC#:________________ Patient DOB:_____/_____/______ Sex:______ (M/F)**

Trilogy Non-Invasive Ventilator (HCPCS E0466)

Date of Service ___________________________________

Length of Need___________________________________

Primary Diagnosis and Code:

Chronic Respiratory Failure (J96.10)
Chronic Respiratory Failure w/Hypoxia (J96.11)
COPD (J44.9)
Chronic Respiratory Failure w/ Hypercapnia (J96.12)
Cystic Fibrosis (E84.8)
Bronchiectasis (J47.)
Acute/Chronic Respiratory Failure (J96.20)
Acute/Chronic Resp. Failure w/hypoxia (J96.21)
Acute/Chronic Resp. Failure w/hypercapnia (J96.22)
Obesity Hypoventilation Syndrome (E66.2)
Chronic Bronchitis (J42.0)
Emphysema (J43.9)
Other___________

Secondary Diagnosis and Code:

ALS (G12.21)
Multiple Sclerosis (G35)
Myopathy (G72.9)
Musculoskeletal Deformities (M21.6)
Sarcoidosis (D86)
Pulmonary Fibrosis (J84._)
Muscular Dystrophy (G71.0)
Paraplegia (G82._)
Disorders of the Diaphragm (J98.6)
Polyneuritis (G62._)
Interstital Lung Disease (J84.9)
Poliomyelitis (_______)
Myasthenia Gravis (G70._)
Kyphoscoliosis (M41.__)
Other________________

Trilogy NIV Settings & Supplies

Primary Settings:

AVAPS-AE
Max Pressure______ PS Min_______ PS Max________
EPAP Min________ EPAP Max_______ Vt______

Secondary Settings:

Assist Control with Mouthpiece Ventilation

Pressure Control with Mouthpiece Ventilation

Vt_______ IPAP_______ EPAP______

Additional Info: Titrate pressures for patient comfort and optimum therapy / Adjust Vt per patient comfort

Frequency & Usage

Continuous Nocturnal Supp O2 Other

Supplies:

Heated Humidifier (E0562)
Bacteria Filters-5/month (A9900)
Ventilator Circuit 2-6/Month (A9900)
Disposable H2o Chamber-5/month(A9900)
Sterile H2o - 30/month (A4217)
MPV Circuit (A4618)
Interface (Patient Preference)
 Full Face Mask (A7030) – 1 per every 3 months
 Full Face Cushion (A7031) – 2 per 1 month

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

____
Provider's Signature Date

____
Provider's Name

NPI: _________________ Telephone: ________________