


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

Date of Last Provider Visit \_\_\_\_\_

<b>Supplier Name, Address, Telephone &amp; NSC#:</b>   <p>901 N. Leatherleaf Loop Wasilla, AK 99654 NSC#: 1267160003 Phone: (907) 357-7882 Fax: (907) 357-7883</p>	<b>Patient Name, Address, Telephone &amp; HIC#:</b>  (____) _____ - _____ HIC#: _____ Patient DOB: ____/____/____ Sex: ____ (M/F)
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**Trilogy Non-Invasive Ventilator (HCPCS E0466)**

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, uncomplicated (J47.9)
- 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. \_)
- Interstitial 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      PRN

**Supplies:**

- Heated Humidifier (A9999)
- Bacteria Filters-5/month (A9999)
- Reusable Ventilator Circuit 1 every 3 months (A9900/A9999)
- Disposable H2o Chamber-1/month(A9999)
- Sterile H2o - 31,000 mL/max (A4217)
- MPV Circuit- 4/month (A4618)
- Interface (Patient Preference)
  - Full Face Mask (A7030) – 1 per every 3 months
  - Full Face Cushion (A7031) – 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: \_\_\_\_\_