

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

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#:



901 N. Leatherleaf Loop
Wasilla, AK 99654

NSC#: 1267160003
Phone: (907) 357-7882
Fax: (907) 357-7883

Patient Name, Address, Telephone & HIC#:

(____) _____ - _____ 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, 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 (A9900)
- Ventilator Circuit 2-6/Month (A9900)
- Disposable H2o Chamber-5/month(A9900)
- Sterile H2o - 30/month (A4217)
- MPV Circuit- 4/month (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: _____