℞ 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#:**
PROCARE HOME MEDICAL **4215 Credit Union Dr.** **Anchorage, AK 99503** **NSC#: 1267160001** **Phone: (907) 274-0770** **Fax: (907) 274-0773**	**(_____) _____ - _____ HIC#:_____** **Patient DOB:_____/_____/_____ Sex:_____ (M/F)**

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.___)
- ☐ 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 ☐ 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 - 31,000mL max/mo (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: _____