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

Date of Last Provider Visit _____

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & Insurance ID#:**
PROCARE HOME MEDICAL **901 N** Leatherleaf Lp Wasilla**, AK 99654** **NSC#: 1267160003** **Phone: (907) 357-7882** **Fax: (907) 357-7883**	**(_____) _____ - _____ Ins ID#:_____** **Patient DOB:_____/_____/_____ Sex:_____ (M/F)**

According to the CMS National Coverage Determination for DME (section 280.1), Non-Invasive Ventilators are: "Covered for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.

☐ Trilogy Non-Invasive Ventilator (HCPCS E0466)

Length of Need _____

Diagnosis:

- ☐ Chronic Respiratory Failure (J96.10)
- ☐ Chronic Respiratory Failure w/ Hypoxia (J96.11)
- ☐ Chronic Respiratory Failure w/ Hypercapnia (J96.12)
- ☐ Acute/Chronic Resp. Failure (J96.20)
- ☐ Acute/Chronic Resp. Failure w/ Hypoxia (J96.21)
- ☐ Acute/Chronic Resp. Failure w/ Hypercapnia (J96.22)

Consequent to:

- ☐ COPD (J44.9)
- ☐ ALS (G12.21)
- ☐ Multiple Sclerosis (G35)
- ☐ Myasthenia Gravis (G70.00)
- ☐ Muscular Dystrophy (G71.00)
- ☐ Paraplegia (G82.20)
- ☐ Quadraplegia (G82.50)
- ☐ Other: _____

- ☐ Sarcoidosis (D86.9)
- ☐ Obesity Hypoventilation Syndrome (E66.2)
- ☐ Pulmonary Fibrosis (J84.10)
- ☐ Interstitial Lung Disease (J84.9)
- ☐ Unspecified kyphosis, thoracic region (M40.204)
- ☐ Musculoskeletal Deformities (M95.9)
- ☐ Other: _____

Trilogy NIV Settings & Supplies

Primary Settings:

☐ AVAPS-AE
Max Pressure_____ PS Min_____ PS Max_____

EPAP Min_____ EPAP Max_____ Vt_____

Secondary Settings:

☐ Assist Control via Mouthpiece Ventilation Vt_____

☐ Pressure Control via Mouthpiece Ventilation
IPAP_____ EPAP _____

Additional Info:

☐ Respiratory Therapist to titrate pressures and/or adjust Vt for optimal therapy and patient comfort.

Frequency & Usage

☐ Continuous ☐ Nocturnal ☐ PRN

☐ Supplemental Oxygen Bleed In

Supplies:

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

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: _____