


**R WRITTEN ORDER AND MEDICAL JUSTIFICATION  
NEBULIZER AND OXIMETER**

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

<b>Supplier Name, Address, Telephone &amp; NSC#:</b>  4215 Credit Union Dr. Anchorage, AK 99503 Phone: (907) 274-0770 Fax: (907) 274-0773 NSC#: 1267160001	<b>Patient Name, Address, Telephone &amp; HIC#:</b>  (____) _____ - _____ HIC#: _____ Patient DOB: ____/____/____ Sex: ____ (M/F)
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We have been asked to provide the following equipment to the patient named above. Please review and verify this information by completing any of the highlighted areas, and date and sign at the bottom. We suggest you keep a copy of this for your records.

**NEBULIZER AND SUPPLIES:**

**OXIMETER:**

Diagnosis and Code: \_\_\_\_\_

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Length of Need (# of months) \_\_\_\_\_ 1-99 (99=life)

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Patient Height: \_\_\_\_\_ ft. in. Weight: \_\_\_\_\_ lbs.

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- Aerosol (Nebulizer) Machine (E0570)
- Nebulizer Cup, Reusable (A7005) – 1 per 6 months
- Mask, Adult (Nebulizer) (A7015) – 1 per 1 month
- Mask, Pediatric (Nebulizer) (A7015) – 1 per 1 month
- Mask, Trach (Nebulizer) (A7525) – 1 per 1 month

- Continuous (E0445)  
\_\_\_\_\_ # hr/day  
Alarm Settings:  
Saturation (PO2): High \_\_\_\_\_ Low \_\_\_\_\_  
Pulse: High \_\_\_\_\_ Low \_\_\_\_\_

Medication: \_\_\_\_\_

- Probes, Disposable (A4606) – 20 per 1 month

- Non-Continuous / Spot Checking (E0445)

\_\_\_\_\_

\_\_\_\_\_ # times/day

**MEDICAL NECESSITY INFORMATION:**

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REQUIRED CRITERIA

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A small volume nebulizer is necessary to administer the following types of medication:

Does the patient have a condition that requires monitoring of the oxygen saturation level?

- Beta-adrenergics, corticosteroids, or cromolyn for management of obstructive pulmonary disease.
- Gentamicin, tobramycin, amikacin, or dornase alpha for management of cystic fibrosis.
- Pentamidine for patients with HIV.
- Mucolytics (other than dornase alpha) for persistently thick or tenacious secretions.
- Cortizosteriods or other anti-inflammatory medication for the long term treatment and management of asthma.

- Y  N

Has a metered dose inhaler (MDI) with and without a reservoir or spacer device been used or considered, and found not sufficient for the administration of the needed inhalation drug?

**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.**

- Y  N

\_\_\_\_\_  
Provider's Signature Date

\_\_\_\_\_  
Provider's Name

NPI: \_\_\_\_\_ Telephone: \_\_\_\_\_