Select Branch

NON-INVASIVE VENTILATION Order Form

Please provide copies of both patient's DEMOGRAPHIC and INSURANCE information.

Patient Name: _____ ***Date Prescribed:*** _____ /_____ /_____

Address: _____ Insurance: _____

City/Zip: _____ Gender: _____ Length of need: ____~~99~~_____

Home Phone/Cell#: _____ Diagnosis (Check all that apply):

☐ Neuromuscular Disease, describe: _____

Height: _____ Weight: _____ D.O.B: _____ ☐ Thoracic Restrictive Disease, describe: _____

All services require a method of payment (credit card, bank information) in addition to insurance information prior to delivery.

☐ Chronic Respiratory Failure consequent to COPD

☐ Other: _____

DEVICE MODES & SETTINGS

☐ Non-Invasive Ventilation (E0466)

Hours of Use: ☐ During Sleep ☐ Continuous ☐ Other: _____ ☐ Mouthpiece Ventilation

EPAP Min: _____ EPAP Max: _____ PS Min: _____ PS Max: _____ Target Vt: _____(6-8 cc/kg IBW) ☐ Titrate Volume +/-100mL

WITH: (select one)

☐ **TRILOGY EVO AVAPS AE** Breath Rate: Auto _____ *or* _____(15-30) iTime if Fixed Rate:_____(0.8-1.5 sec) Max Pressure: _____ (≤ 50)

☐ **MPV PC** IPAP: _____(4-40cmH20) EPAP: _____(0-25cmH20) Rate: _____ (0-30cmH20) iTime: _____(0.3-3.0sec) Rise: _____(1-6)

☐ **MPV AC** Vt: _____ml PEEP: _____(0-25cmH20) Rate: _____ (0-30bpm) iTime: _____(0.4-3.0sec)

☐ **LUISA TTV-VAPS AE** Breath Rate: Auto _____ *or* _____(15-30) iTime if Fixed Rate:_____(0.8-1.5 sec) SPEED: _____ (1-3)

and

☐ **High Flow Therapy (HFT)** _____ Flow Rate L/min

and

☐ **MPVv** Vt: _____ml IPAP: _____cmH20 *or* ☐ **MPVp** IPAP: _____cmH20 iTime: _____sec

☐ **ASTRAL iVAPS** Target Breath Rate: _____(15-30) (Patient Height & Weight are mandatory)

and

☐ **MPV ACV** iTime: _____ml Vt: _____ *or* ☐ **MPV PACV** Pcontrol: _____ iTime: _____

MASK

Non-Invasive Interface: ☐ Fit to patient comfort ☐ Prescribed: Make: _____ Model: _____ Size: _____

OXYGEN

Oxygen Bleed in:_____ lpm or FiO_2 _____% For O_2 Bleed in, titrate O_2 to 90% or to _____% ☐ Oximetry at set up ☐ Overnight Oximetry

The patient's medical record(s) may include one or more for the following:

1. An arterial blood gas study that demonstrates chronic hypercapnia; PaCO2 ≥ 53 mmHg;
2. Diagnosis of severe COPD demonstrated by pulmonary function testing; FEV1 ≤ 50% of predicted;
3. Forced Vital Capacity < 50% of predicted or MIP < 60 cmH2O (neuromuscular disease);
4. History of respiratory related hospital admissions within the past 12 months;
5. Trial or consideration of lesser therapy (Bi-level) and based on the treating physician's clinical judgement a ventilator is the most appropriate treatment plan.

☐ **Please expedite Prior Authorization** Date of Discharge: _____

Physician's Signature: _____ ***Date:*** _____/_____/_____

Physician's Printed Name: _____ Ph: _____ Fax: _____

Address: _____ ***NPI:*** _____

Name of Person Completing Form: _____

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