Medical Service Company | MSC Sleep — Division of Medical Service Company

Please fax completed form to 1-877-824-1411

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:

Height: _____ Weight: _____ D.O.B: _____

☐ Chronic Respiratory Failure (J96.10) subsequent to Chronic Obstructive Pulmonary Disease (J44.9)

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

☐ Other: _____

DEVICE MODES & SETTINGS

☐ Non-Invasive Ventilation (E0466) Hours of Use: ☐ During Sleep ☐ Continuous ☐ Other: _____

☐ ASTRAL

Device Mode: ☐ iVAPS AE ☐ Other: _____

EPAP Min: _____ cmH_2O (2-25)

EPAP Max: _____ cmH_2O (2-25)

PS Min: _____ cmH_2O (0-50)

PS Max: _____ cmH_2O (0-50)

Vt: _____ ml

Target Pt. Rate: _____ 15-30bpm

☐ TRILOGY

Device Mode: ☐ AVAPS AE ☐ Other: _____

Max Pressure: _____ cmH_2O (6-50)

PS Min: _____ cmH_2O (2-40) PS Max: _____ cmH_2O (2-40)

EPAP Min: _____ cmH_2O (4-25) EPAP Max: _____ cmH_2O (4-25)

Target Vt: _____ AVAPS Speed: _____ cmH_2O/min (1-5)

Resp Rate: ☐ Auto or ☐ Fixed: _____ bpm (0-60)

Insp Time (if not auto rate): _____ Rise Time: _____ (1-5)

MASK

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

MOUTHPIECE VENTILATION

☐ AC or ☐ PC AC Flow Pattern: ☐ Ramp ☐ Square

AC Settings: Vt mL: _____ (200 to 1500) PEEP: _____ cmH_2O (0-25) Breath rate: _____ bpm (0-30) Insp time: _____ sec (0.4-3.0)

PC Settings: IPAP: _____ cmH_2O (4-40) EPAP: _____ cmH_2O (0-25) Breath rate: _____ bpm (0-60) Insp time: _____ sec (0.3-5.0) Rise Time: _____ (1-6)

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

Please include the following documentation:

- Face to Face evaluation documenting
  - Patient's medical history and respiratory ailment
  - For COPD patients ONLY, one of the following:
    - $pCO_2 \geq 52$ mmHg or/and FEV1<50% of predicted; OR
    - pCO_2 between 48-51 mmHg or FEV1<51-60% of predicted obtained AND have two or more respiratory-related hospital admissions within the past 12 months.
  - Reason for medical necessity, including why the patient requires mechanical ventilatory support **due to severe and/or life-threatening disease state** and consequences if patient does not receive
  - If patient was on Bi-Level therapy as an outpatient, why the current therapy is being replaced by NIV
- Other documentation if available:
  - For neuromuscular patients, FVC or MIP/NIF test results
  - For Restrictive Thoracic patients, pCO_2 or FVC test results
  - Last hospital admission/readmission

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

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

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

Physician's Address: _____ ***NPI:*** _____

Name of Agent Completing Form: _____

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