NON INVASIVE VENTILATION (NIV) ORDER FORM

Integrated HomeCare Services
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PATIENT NAME: _____ D.O.B. _____ ORDER DATE: _____

PRIMARY PHONE NO. _____ PRIMARY INSURANCE: _____

ID # _____ GROUP # _____

DIAGNOSIS ICD-10: A specific ICD-10 code must be provided either on the line below or in the patient's medical records.
Please check the appropriate qualifying diagnosis and write in the code. Ranges will not be accepted.

- ❑ Chronic Respiratory Failure _____ (ICD-10 code)
- ❑ Consequent to Chronic Obstructive Pulmonary Disease _____ (ICD-10 code)
- ❑ Other: _____ (description) _____ (ICD-10 code)

PRESCRIBED MEDICAL EQUIPMENT:

- ❑ Trilogy
- ❑ Mask, Headgear, Tubing & Filters
  Supplies used with PAP: A7027 Oral/Nasal Combo Mask, A7028 Repl. Oral/Nasal Combo Mask, A7030 F/F Mask, A7031 Face Mask Intrfce Repl., A7032 Repl. Cshn, A7033 Nsl Pillows, A7034 Nsl Mask, A7035 Hdgr, A7036 Chin Strp, A7037 Tubing, A7038 Disp Fltrs, A7039 Non Disp Fltrs, A7046 Hmdfr Chmbr (Refer to Medicare/Insurance Guidelines for allowed quantities)
- ❑ E0562 Heated Humidifier
- ❑ A4604 Heated Tubing
- ❑ E1390 Nocturnal Oxygen Concentrator
  _____ LPM to bleed in with NPAP
- ❑ Other _____

DEVICE MODES AND SETTINGS

Device mode:

- ❑ AVAPS AE
- ❑ Mouthpiece Ventilation (MVP)
- ❑ Other: _____

Nocturnal AVAPS AE device settings:
Pressure Max: _____
PS Min: _____ PS Max: _____
EPAP Min: _____ EPAP Max: _____
Vt volume: _____
❑ Check to allow adjustment within ± 100 cc volume
Rate: _____
Inspiratory time: _____ (if rate = "auto" then "N/A")

AVAPS rate/speed: _____ (may be left blank)
Supplemental 02 _____ LPM

- ❑ For patients using oxygen, please titrate 02 saturation to 90% or to _____%
- ❑ Overnight oximetry to be performed on day of Setup, using prescribed oxygen

Hours of use: ____ During sleep ____ While awake
Dual settings? ____ Yes or _____ No
If yes, please complete daytime mouthpiece
Ventilation (MPV) settings: (complete AC Mode or PC Mode, not both)
AC Mode: iTime _____ Vt _____, or
PC Mode: iPAP _____ iTime _____

DURATION

❑ LIFETIME (99 Months) or _____ Months

PLEASE INCLUDE ALL OF THE FOLLOWING DOCUMENTATION:

- FOR HOSPITAL DISCHARGE ONLY, the patient has completed a trial on the device that is being ordered
- Face-to-face evaluation/hospital medical records within last 6 months documenting:
  - ❑ Patient's medical history and respiratory ailment
  - ❑ For Chronic Respiratory Failure due to COPD, one of the following:
    - _____ mmHG (PC02 ≥ 52 mmHg) or
    - _____ % (FEV1 ≤ 50% of predicted); **OR**
    - _____ mmHg (PC02 between 48-51 mmHg) or
    - _____ % (FEV1 ≤ 51-60% of predicted obtained) **AND** have 2 or more respiratory-related hospital admissions within the past 12 months
- Reason for medical necessity, including why the patient needs pressure support ventilation **due to severe and/or life-threatening disease state**, and the consequences if the patient does not receive the benefit of pressure support ventilation
- If patient was previously on bi-level with or without rate as an outpatient, documentation required as to why the current therapy is being replaced by NIV

The above patient has been diagnosed with Chronic Respiratory Failure due to COPD. The above prescribed treatment has been considered the best alternative therapy for this patient. If left untreated it is potentially life-threatening Patients will be re-evaluated yearly to review symptoms. This prescription and diagnosis certifies that the above ordered services are medically necessary for this patient.

PHYSICIAN SIGNATURE: _____ DATE: _____

Physician Name: _____

Address: _____

_____

Office Phone: _____ NPI# _____

Please Provide us with the following:
Order Contact Name: _____
✔ A clear copy of the patient's insurance care/info sheet
✔ A clear copy of the patient's most recent sleep study
✔ **ALL RELEVANT EQUIPMENT, DIAGNOSIS, & START DATE FIELDS COMPLETED**

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