Non-Invasive Ventilation Form

NIV Fax: (872) 469-1691

FORT Advantage Care
RESPIRATORY AND MEDICAL EQUIPMENT

Sales Representative _____ Phone_____

Referral Source

Referral name_____ Referral contact name_____

Order date_____ Phone_____ Fax_____

Patient Information

Patient name_____DOB_____

Home Phone_____ Mobile Phone_____

Delivery address: Street_____City_____State____Zip_____

Non-Invasive ventilation is covered for: S3evere neuromuscular or restrictive thoracic diseases, and chronic respiratory failure consequent to severe chronic obstructive pulmonary disease (COPD).

Diagnosis ICD-10: A specific ICD-10 code must be provided either on the line below or in the patient's EMR. 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) _____

By my signature, I authorize that the following activities shall be performed on my patient at setup, the day after setup, at the end of the first week, repeated monthly for 3 months and then quarterly thereafter: Clinical assessment to include but not be limited to heart rate, respiratory rate, and blood pressure, breath sounds, end tidal CO2 Monitoring, spirometry FEV1 and FVC, and oximetry testing on prescribed oxygen,

Patient Height: _____

PLEASE INCLUDE ALL OF THE FOLLOWING REQUIRED DOCUMENTATION

- Copy of patient demographics and insurance information
- **FOR HOSPITAL DISCHARGE ONLY**, the patient has completed a trial on the device being ordered
- For patients with chronic respiratory failure consequent to COPD, both diagnoses must be included in the documentation
- Documentation from the patient's face to face evaluation/medical records within the last 6 months that support:

  -Patient's medical history and respiratory ailment

  -ONLY for patients with CRF consequent to COPD, one of the following:

  ● pCO_2 ≥ 52 mmHg or FEV1 ≤ 50% of predicted; OR

  ●pCO_2 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

  -The medical necessity for pressure support ventilation including, but not limited to, progress of the patient's disease state, prior treatment results and current treatment plans

  -If patient was previously on bi-level with or without rate as an outpatient documentation of why the bi-level therapy is not sufficient for the patient

Other documentation, ONLY IF AVAILABLE:

-For Neuromuscular patients, FVC or MIP/NIF test results

-For Restrictive Thoracic patients, FVC or MIP/NIF test results

-Recent hospital admission/readmission

EQUIPMENT ORDERED

Home Ventilator, Any Type, Used with Non-Invasive Interface (E0466) with supplies

□ E0562 Heated Humidifer

□ Mouthpiece Ventilation (MPV) Circuit

□ Non-Vented Full Face Mask: Fit to patient comfort

□ Vented Mask: Any type with PAP Circuit **(ONLY FOR USE WITH PAC MODE)**

DEVICE MODES AND SETTINGS

Device Mode:

□ PS with Safety (Vi) □ PAC □ Other_____

□ Mouthpiece Ventilation

Nocturnal Device Settings:

PS Max_____ PS/Pcontrol/IPAP Minimum_____

PEEP/EPAP_____ RR_____ Safety Vt Target_____

Check to allow adjustment within ±100 cc volume □

For PS with Safety (Vt):

(Ti Min/Max range: 0.2 second—4.0 seconds)

Ti Min_____ Ti Max_____

OR check to titrate to patient comfort □

For PAC: (Ti range: 0.2 second—5.0 seconds Ti_____

OR check to titrate to patient comfort □

□ No O_2 needed OR

□ Supplemental O_2 starting at _____LPM and titrate O_2 Saturation to 90% **OR** to _____%

□ Overnight oximetry to be performed on day of setup, using prescribed oxygen

Hours of use: □ During sleep □ PRN while awake

Dual Settings? □ Yes **OR** □ No

If Yes, please complete daytime mouthpiece ventilation (MPV) Settings: (complete ACV or PACV Mode, not both)

ACV Mode: Ti_____ Vt_____, **OR** PACV Mode: Pcontrol_____ Ti_____

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering these items for this patient is a clinical decision made by me based on clinical need s, and my records concerning this patient support he medical need for the items prescribed.

Physician name_____NPI_____

Physician signature_____Date_____