PAP Rx/ LMN

Order date: _____ ***Fax medical records & Rx to*:** _____

Start date: _____ **(Order and start date must be completed. It may be the same date.)**

The patient: _____ **DOB**:_____ **Chart or HIC #**:_____
Responds well to therapeutic positive air pressure.

Patient's Address:

1. ☐ **Auto PAP OR** ☐ **C-PAP** and Heated Humidifier at: _____cm H_2O. (Max: 20 cm H_2O).

2. ☐ **BiLevel S** and Heated Humidifier at: IPAP: _____ cm H_2O, EPAP: _____ cm H_2O (Max: 25 cm H_2O).

3. ☐ **BiLevel Auto** and Heated Humidifier at: IPAP Max: _____cm H_2O, EPAP Min: _____ cm H_2O (Max: 25 cm H_2O).

4. ☐ **BiLevel S/T** and Heated Humidifier at: IPAP: _____ cm H_2O, EPAP: _____cm H_2O, and Breathing Rate of: _____ per min (Max: 30 cm H_2O).

5. ☐ **ResMed VPAP Adapt SV™** and Heated Humidifier at: EEP: _____cm H_2O Pressure. Min. Pressure Support: _____cm H_2O

(Range 3–6). Max Pressure Support: _____cm H_2O (Range 8–16). Backup Rate = AUTO (EEP + Max Pressure must not exceed 25 cm H_2O)

6. ☐ **Respironics BiPAP autoSV Advanced™** and Heated Humidifier at: EPAP Min: _____cm H_2O, EPAP Max: _____cm H_2O,

PS Min: _____cm H_2O, PS Max: _____cm H_2O, Max Pressure: _____cm H_2O, Rate: AUTO. Bi-Flex: OFF.
(For treatment of conditions such as periodic breathing, cheyne strokes, Central Sleep Disorders, or Complex Sleep Apnea)

7. ☐ **Respironics AVAPS™** and Heated Humidifier at: IPAP Max _____ cm H_2O, IPAP Min: _____ cm H_2O, EPAP: _____ cm H_2O, SET V_t: _____, Rise _____, Rate _____.

C-PAK *(Complete Positive Air Kit)*

☐ 1 Nasal/pillows mask & headgear every 3 months
☐ 1 Full-face mask & headgear every 3 months
☐ 1 Hybrid mask & headgear every 3 months
☐ 1 Oral mask & headgear every 3 months
☐ 1 Disposable water chamber every 6 months
☐ 1 Chin strap every 6 months
☐ 1 tubing every 3 months
☐ _____

☐ 2 Nasal cushions/pillows every 1 month
☐ 1 Full-face cushion every 1 month
☐ 2 Hybrid cushions/pillows every 1 month
☐ 1 Headgear every 6 months
☐ 1 Non disposable filter every 6 months
☐ 2 Disposable filters every 1 month
☐ 1 Heated wire tubing every 3 months
☐ _____

Diagnosis: ☐ Obstructive Sleep Apnea G47.33 ☐ Central Sleep Apnea G47.31 ☐ ALS G12.21 ☐ COPD J44.9 ☐ Other _____

X_____ _____ X_____
Physician Signature Print Name Date
N.P.I. #: _____ ***The signature and signature date cannot be stamped.***

STATEMENT OF MEDICAL NECESSITY: PAP is necessary for Lifetime

- **The beneficiary has had an in person examination with a treating physician within six (6) months prior to the date of this prescription. The beneficiary has been evaluated for a condition that supports the need for the items being prescribed.**

The above patient has undergone a clinical or polysomnographic evaluation. This evaluation confirmed the diagnosis of apnea or respiratory failure. As the patient showed both significant oxygen desaturations and abnormalities secondary to apnea, nasal CPAP/BiPAP is medically necessary. HEATED HUMIDIFIER: The patient suffers from a dry airway and difficulty in breathing. The appropriate remedy to this problem is the addition of an in-line heated Humidifier, used in conjunction with the positive airway pressure. The added moisture will allow my patient to use the treatment device successfully. C-PAP SUPPLIES: It is necessary to replenish supplies so that incidents of respiratory infections are reduced and patient compliance can be improved. (Revised: 11/5/2015)