Dedicated NIV Fax: (855) 474-3572

ACE
APRIA CLINICAL EVIDENCE

Astral Non-Invasive Ventilation Form

Your Apria Representative ____________ **Branch Location** ____________ **Phone** ____________

REFERRAL SOURCE

Referral name ____________ Referral contact name ____________

Order date ____________ Phone ____________ Fax ____________

PATIENT INFORMATION

Patient name ____________ (Last) ____________ (First) DOB ____________

Home phone ____________ Mobile phone ____________

Delivery address: Street ____________ City ____________ State ____ Zip ____________

NIV is covered for: Severe neuromuscular or restrictive thoracic diseases, and chronic respiratory failure consequent to severe chronic obstructive pulmonary disease. For some payors (excluding Medicare), NIV may be covered for obesity hypoventilation syndrome.

Diagnosis ICD-10: **A specific IDC-10 code must be provided either on the line below or in the patient's chart notes. 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, 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 CO_2 monitoring, spirometry FEV1 and FVC, and oximetry testing on prescribed oxygen, at rest and with activities.

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 that is being ordered
- Face-to-face evaluation/hospital medical records within last 6 months documenting:
  - **Patient's medical history and respiratory ailment**
  - **For COPD patients ONLY, one of the following:**
    - **$pCO_2 \geq 52$ mm Hg or FEV1 $\leq$ 50% of predicted; OR**
    - **pCO_2 between 48–51 mm Hg or FEV1 $\leq$ 51–60% of predicted obtained AND have 2 or more respiratory-related hospital admissions within the past 12 months**
  - **For non-Medicare OHS patients ONLY, all of the following:**
    - **$pCO_2 \geq 45$ mm Hg**
    - **Body Mass Index (BMI) > 40**
    - **Diagnosis of obstructive sleep apnea (OSA)**
  - **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**
- Other documentation, ONLY 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

EQUIPMENT ORDERED

Pressure support ventilator with related supplies (E0464)

☐ E0562 Heated Humidifier ☐ 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)**

Estimated length of need: ________ months (99 = lifetime)
Patient height: ____________

DEVICE MODES AND SETTINGS

Device Mode:
☐ PS with Safety (Vt) ☐ 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 ☐

Please check all that apply:
Supplemental O_2: ______ LPM
☐ For patients using oxygen, please 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 this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the items prescribed.

Physician name ____________ **NPI #** ____________

Physician signature ____________ **Date** ____________

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