



# Prescription for nCPAP and BIPAP

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ DOB: \_\_\_\_\_

**Diagnosis: Obstructive Sleep Apnea—327.23**

## Therapeutic Equipment Ordered

- NCPAP set at \_\_\_\_\_ cmH<sub>2</sub>O pressure with C-Flex (adjust cflex for patient comfort)
- Bi-level (BIPAP) set at \_\_\_\_\_ cmH<sub>2</sub>O inspiratory pressure (IPAP)
- BIPAP set at \_\_\_\_\_ cmH<sub>2</sub>O expiratory pressure (EPAP)
- Auto CPAP: four-six week trial
  - First 2-4 weeks capture data
  - 3-4 weeks finalize pressure requirements
  - After patient tries auto-CPAP and decides he/she wants to continue therapy, SleepEasy Therapeutics may set CPAP at 95% pressure.
- Humidification: heated humidifier
- Mask/Pillow/Supplies: Accessories/supplies as needed per discretion of supplier. May include mask, headgear, nasal pillows, chinstrap, etc.
  - \_\_\_ A7030 full face mask—1 every 3 months
  - \_\_\_ A7030 full face mask—1 every 3 months
  - \_\_\_ A7030 replacement nasal pillow—1 every 6 months
  - \_\_\_ A7031 replacement face mask cushion—1 every 6 months
  - \_\_\_ A7032 replacement nasal cushion—1 every 6 months
  - \_\_\_ A7034 CPAP mask—1 every 3 months
  - \_\_\_ A7035 CPAP headgear—1 every 6 months
  - \_\_\_ A7036 chin strap—1 every 6 months
  - \_\_\_ A7037 CPAP tubing—1 every month
  - \_\_\_ A7038 filter disposable—2 every month
  - \_\_\_ A7039 filter re-usable and supplies—1 every 6 months
  - \_\_\_ A7046 replacement H2O humidity chamber—1 every 6 months
  - \_\_\_ A4604 F&P Heated CPAP Circuit—1 every 6 months

**Duration of Need: 99 Months (lifetime=99 months)**

## Coverage Criteria

1. Was a facility-based Polysomnogram done?
  - Yes; date: \_\_\_\_\_ hospital site: \_\_\_\_\_
  - No
2. Please check the appropriate statement below.
  - The AHI is at or greater than 15 events per hour.
  - The AHI is from 5-14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia or hypertension, ischemic heart disease or history of stroke.

## Comments:

I certify that the above named patient requires the use of the durable medical equipment listed.

Physician Name: \_\_\_\_\_ UPIN #: \_\_\_\_\_  
 Clinic Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Fax completed form to our office at: 701-356-5798