APRIA®

Non-Invasive Ventilation - HMV Order

Apria Representative _____ **Branch Location** _____ **Fax completed form to** _____ **Phone** _____

REFERRAL SOURCE _____

Referral name _____ Referral contact name _____

Order date _____ Phone _____ Fax _____

PATIENT INFORMATION

Patient name _____ (LAST) _____ (FIRST) DOB _____

Home phone _____ Mobile phone _____ Patient height _____ MBI/INS ID # _____

Patient address: Street _____ City _____ State _____ Zip _____

When coverage guidelines are met, non-invasive ventilation (NIV) via a home mechanical ventilator (HMV) is covered for: Severe 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 chart notes.

☐ Chronic Respiratory Failure _____ (ICD-10 code) consequent to Chronic Obstructive Pulmonary Disease _____ (ICD-10 code)

☐ Other (description): _____ _____ (ICD-10 code)

PRESCRIBED EQUIPMENT

Code Status: Resuscitate? ☐ Yes ☐ No **Advance Directive?** ☐ Yes ☐ No

Equipment ordered: Home Ventilator

- ☐ Used with Non-Invasive Interface (E0466) and all needed supplies.
- ☐ Used as dual-function respiratory device with cough (E0468) and all needed supplies.
- ☐ Heated Humidifier (E0562)

Estimated length of need: _____ **months** (99 = lifetime)

Hours of use: ☐ During sleep ☐ PRN while awake

- ☐ For patients currently on O_2, titrate O_2 to maintain oxygen saturation to 90% or to _____%
- ☐ Overnight oximetry to be performed on day of setup, using prescribed oxygen

Device: ☐ Initial ☐ Setting Change ☐ Device Replacement – *Existing device settings are retained with new settings until trial is completed.*

PRESCRIBED SETTINGS FOR NIV ON A HOME MECHANICAL VENTILATOR

☐ Licensed Practitioner is authorized to titrate ventilator parameters only within prescribed mode of ventilation and ranges to maximize patient's ventilatory support, adherence to therapy, and comfort.

MODEL and MODE ☐ **Substitution Permissible**

☐ **VHome/VPro/V+C:**	☐ **VIVO 45LS:**	☐ **LUISA:**	☐ **ASTRAL:**	☐ ***Other**
☐ Vol. Targeted PS	☐ PS w/Target Vt + AE	☐ TTV-VAPS AE	☐ IVAPS AE ☐ PAC	
☐ Vol. Targeted Pressure PC	☐ PAC w/Target Vt + AE		☐ IVAPS ☐ PS w/ Safety Vt	

SETTINGS: MIN PS: _____ cmH2O MAX PS: _____ cmH2O PEEP MIN: _____cmH2O PEEP MAX: _____ cmH2O or Fixed PEEP: _____

Rate: _____ Volume: _____ ml or ml/kg Insp. Time: _____ ☐ Bleed in O2 to keep O2 Sats > 90% ☐ O2 Bleed in _____ lpm

☐ **Cough Settings:** ☐ Exsufflation Press: _____ E-Time: _____ Insufflation Press: _____ I-Time: _____ Pause time _____

(Required for V+C) Number of Cycles: _____ Frequency: _____ ☐ BID ☐ PRN ☐ Titrate to achieve effective cough

☐ **For MPV:** ☐ Pressure MPV: I-Time: _____ Pressure: _____ ☐ Volume MPV Mode: I-Time: _____ Volume: _____

☐ PS Mode (Astral only): iTime: _____ PS: _____ *Note: MPV must be ordered in conjunction with an NIV therapy mode.

☐ Luisa only: ☐ MPVv Volume: _____ IPAP _____ ☐ MPVp IPAP _____ I-Time _____

☐ **For High Flow :** ☐ Flow Rate: _____ lpm O2 Bleed in _____ lpm **OR** ☐ Bleed in O2 to keep O2 Sats > 90% *Note: HFT must be ordered with NIV

☐ * **Other Device:** _____ Primary Mode: _____ MIN PS: _____ MAX PS: _____

Rate: _____ Volume _____ml EPAP MIN/Fixed: _____ EPAP MAX: _____

☐ **Secondary Settings:** _____

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. Further, I acknowledge that I have considered, and decided against, ordering a Bi-Level device for this patient.

Print prescriber's name _____ **NPI #** _____

Prescriber's address _____

Prescriber's signature _____ **Date** _____

©2025 Apria Healthcare Group LLC