APRIA®

Respiratory Order Form

Fax completed form to: _____

Apria Representative _____ **Branch Location** _____ **Phone** _____

REFERRAL SOURCE

Referral name _____ Referral contact name _____

Order date _____ Phone _____ Fax _____

PLEASE SEND PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION, ALONG WITH A SIGNED AND DATED COPY OF THE FACE-TO-FACE EVALUATION AND/OR TEST RESULTS FROM THE PATIENT'S CHART

PATIENT INFORMATION

Patient name _____ DOB _____
LAST FIRST

Address _____ MBI/INS ID # _____

Home phone _____ Mobile phone _____ Email _____

Diagnosis ICD-10: Each diagnosis requires a corresponding ICD-10 code and must be corroborated in the patient's medical record. Please enter the appropriate qualifying diagnoses and corresponding ICD-10 codes. (Note: ranges are not acceptable.)

- ☐ _____ Congestive Heart Failure (I50.20 – I50.43) caused by I27.81 Cor Pulmonale
- ☐ _____ Emphysema (J43.0 – J43.9)
- ☐ _____ Chronic Bronchitis (J41.0 – J42)
- ☐ _____ Chronic Obstructive Pulmonary Disease (J44.0 – J44.9)
- ☐ _____ Other _____

OXYGEN

Estimated length of need _____ months (99 = lifetime)

Stationary oxygen: ☐ Continuous ***or*** ☐ Nocturnal

Liter flow:
O_2 at rest _____ LPM O_2 with ambulation _____ LPM
O_2 for nocturnal _____ LPM

Portable oxygen: ☐ Continuous at _____ LPM ***or*** ☐ OCD
If OCD: ☐ At setting (1 – 6) _____ ***or*** ☐ Titrate the oxygen setting to achieve an SpO_2 of ≥ 90% at rest and during activities of daily living via pulse oximetry; and set up on the appropriate conserving device.
Is the patient mobile within the home? ☐ Yes ☐ No

Route of delivery:
☐ Nasal cannula ☐ Via PAP ☐ Other _____

Date of test _____ **Location** _____

Test Results for Oxygen at Rest (required):
SpO_2% RA resting _____

Test Results for Oxygen with Ambulation (Medicare requires all three tests be performed during the same testing session):
SpO_2% RA resting _____ SpO_2% RA ambulating _____
SpO_2% on O_2 ambulating _____

Testing for O_2 for Nocturnal:
SpO_2% ≤ 88% for _____ hours _____ minutes
Lowest SpO_2 _____

OVERNIGHT OXIMETRY

☐ Overnight oximetry testing on room air to be performed by a Medicare approved IDTF for purposes of oxygen qualification.

NEBULIZER AND SUPPLIES

Estimated length of need _____ months (99 = lifetime)
(Maximum quantities allowed per Medicare guidelines)

- ☐ E0570 Nebulizer with air compressor
- ☐ A7003 Admin set, disposable (2 x 1 mo)
- ☐ A7013 Filter, disposable (2 x 1 mo)
- ☐ A7005 Admin set, non-disposable (1 x 6 mo)
- ☐ A7014 Filter, non-disposable (1 x 3 mo)
- ☐ A7015 Aerosol mask (1 x 1 mo)
- ☐ A7004 Sm vol pneumatic nebulizer (2 x 1 mo)
- ☐ A7007 Large vol nebulizer, disposable, unfilled (2 x 1 mo)
- ☐ A7010 Corr tubing, disposable (100' x 2 mo)
- ☐ A7012 Water collection device (2 x 1 mo)
- ☐ A7525 Trach mask (1 x 1 mo)
- ☐ Other (specify quantity and frequency): _____

Medication _____

Frequency _____ Dose _____

Quantity _____

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.

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

Prescriber's address _____

Prescriber's signature _____ **Date** _____

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MEDICARE REQUIREMENTS FOR O_2 PRESCRIPTION CHECKLIST

To qualify for Medicare coverage of oxygen therapy, please ensure the following:

Arterial Blood Gas (PaO_2) ≤55 mmHg or **Oxygen Saturation** ≤88% during rest; OR

Arterial Blood Gas (PaO_2) 56 mmHg or **Oxygen Saturation 89% at rest; AND**

Patient has any one of the following:

- ☐ 1. Dependent edema suggesting congestive heart failure; OR
- ☐ 2. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF); OR
- ☐ 3. Erythrocythemia with a hematocrit greater than 56 percent.

Exercise Testing Criteria:

- ☐ Saturation at or >88% or >55 PaO_2 RA (room air) rest.
- ☐ Saturation must show a drop to ≤88% during exercise.
- ☐ Saturation must show improvement with exercise while on oxygen.

Sleep Testing Criteria:

- ☐ If the patient's arterial PO_2 is ≥56 mmHg or their arterial oxygen saturation is ≥89% while awake, levels must fall fall below 55 mmHg or 88% during sleep.

Supplier Coordination

- ☐ Complete the Apria Oxygen prescription to order the requested device/therapy.
- ☐ Submit all medical records details to Apria with the prescription.
- ☐ Contact your Apria representative for assistance as needed.

Important Notes:

Documentation must be thorough, include the patient's O_2 levels, and define whether the testing was performed at rest, during exertion, or sleep. Confirm that all test results are noted in the patient's records to comply with Medicare guidelines.

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