APRIA®

Respiratory Assist Devices

Fax completed form to: _____

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

Referral name _____ Referral contact name _____

Order date _____ Phone _____ Fax _____

Patient name _____ DOB _____

Address _____ MBI/INS ID # _____

Home phone _____ Mobile phone _____ Email _____

Respiratory Assist Devices (RADs) may be covered for patients with one of the following: Severe chronic obstructive pulmonary disease (COPD), restrictive thoracic disorders, hypoventilation and central sleep apnea or complex sleep apnea.

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

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

Estimated length of need ____ Months (99=lifetime) Device: ☐ Initial ☐ Setting Change ☐ Device Replacement

☐ E1390 Oxygen Concentrator; bleed in at _____ LPM OR titrate O2 to maintain oxygen saturation to 90% or to _____%

☐ Overnight oximetry to be performed on day of setup, using prescribed oxygen.

☐ Licensed Practitioner may titrate RAD parameters within listed ranges for therapy adherence and patient comfort.

☐ RAD without Backup Rate (E0470) with Heated Humidifier (E0562)

☐ **Resmed AirCurve™ VAuto** ☐ **React Luna G3 bilevel 25A**

☐ Substitution Permissible

☐ Auto S mode
Max. IPAP: _____ cmH_2O (4–25)
Min. EPAP: _____ cmH_2O (4–25)

☐ Spont mode
IPAP: _____ cmH_2O (4–25)
EPAP: _____ cmH_2O (3–25)

Aircurve: PS: _____ cmH_2O (0–10)

Luna Min IPAP: _____ cmH_2O (4-25: min IPAP-min EPAP = Fixed ps)

☐ **Luna** - RESlex™: ☐ OFF ☐ 1 ☐ 2 ☐ 3 ☐ Patient

☐ Luna- Initial Ramp Pressure: _____ * Option to leave ramp time blank to set to patient comfort

☐ **Aircurve** - Easy-Breath ☐ On ☐ Off

☐ Aircurve Ramp time: _____min(s) (Auto, Off, up to 45-60 min max)*

☐ **OR** check box for default settings (IPAP: 25, EPAP: 4, PS: 4)

☐ RAD with Backup Rate (E0471) with Heated Humidifier (E0562)

☐ **Resmed AirCurve™ ASV** ☐ Substitution Permissible

☐ ASV Mode
EPAP: _____ cmH_2O (4–15)
Min. PS: _____ cmH_2O (0–6)
Max. PS: _____ cmH_2O (5–20)
Ramp time: _____ mins (off-45)*
☐ **OR** check box for default settings (IPAP: 5, Min PS: 3, Max PS: 15)
* Option to leave ramp time blank to set to patient comfort

☐ ASV Auto mode
Min. EPAP: _____ cmH_2O (4–15)
Max. EPAP: _____ cmH_2O (4–15)
Min. PS: _____ cmH_2O (0–6)
Max. PS: _____ cmH_2O (5–20)
Ramp time: _____ min(s) (Off-45)*
Backup rate: Automatic (15 BPM)
☐ **OR** check box for default settings (Min. EPAP: 4, Max. EPAP: 15, Min. PS: 3, Max. PS: 15)

☐ RAD with Backup Rate (E0471) with Heated Humidifier (E0562)

☐ I authorize clinical assessments at setup and follow-up as needed, which may include heart rate, respiratory rate, $ETCO_2$, and oximetry checks.

☐ Titrate to achieve High Intensity Setting = PIP ≥ 15 and RR ≥14

VAPS Devices: ☐ **AirCurve™ ST-A** ☐ **Luna G3 VT30**

☐ Substitution Permissible

☐ Timed mode
☐ PAC mode
☐ Spont/timed mode
IPAP: _____ cmH_2O (4–30)
EPAP: _____ cmH_2O (3–25)
Rate: _____ BPM (5-50)
Ti: _____ sec. (0.1- 4.0)

☐ VAPS mode
Height: _____in. (44-100)
Target patient rate: _____ BPM (8-30)
* Target VA: _____ L/min. (1-30)
* Target VT _____ mL
* VT/KG _____ (ml/kg)
EPAP: _____ cmH_2O (3-25)
Min. PS: _____ cmH_2O (0-20) or
- Min Ipap (Luna): _____ cmH_2O (4-30)
Max. PS: _____ cmH_2O (0-27) or
- Max Ipap (Luna): _____ cmH_2O
Ti: _____ sec. (0.1-4.0)

ST Devices: ☐ **AirCurve™ ST** ☐ **Luna G3 VT30**

☐ Substitution Permissible

☐ Spont/ timed mode IPAP: _____ cmH_2O (4 - 25 or 30)
EPAP: _____ cmH_2O (3 - 25 or 30)
Rate: _____ BPM (5- 30) Ti: _____ sec (0.3-1 sec)*
Optional

STANDARD A4604 Tubing w/ heating element (1x3 mo)
OR ☐ A7037 Tubing (non-heated if desired) (1x3 mo)
☐ A7039 Filter, non-disposable (1x6 mo)
☐ A7046 Humidifier tub, disposable (1x6 mo)
☐ A7038 Filter, disposable (1x1 mo)

☐ A9279 Monitoring feature/device (stand -alone or integrated)
☐ A7035 Headgear (1x6 mo)
☐ A7029 Repl nasal pillow combo mask (2x1 mo)
☐ A7032 Cushions (2x1 mo)
☐ A7033 Nasal pillows (2x1 mo)
☐ A7028 Repl oral cushion combo mask (2x1 mo)

☐ Mask: Patient Preference: _____
☐ A7030 Full face mask (1x3 mo)
☐ A7027 Combo oral/nasal mask (1x3 mo)
☐ A7031 Full face mask interface (1x1 mo)
☐ A7034 Nasal interface mask/cannula (1x3 mo)
☐ A7036 Chin strap (1x6 mo)

☐ **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. When checked, I authorize clinical assessments—including heart rate, respiratory rate, $ETCO_2$ spot checks, and oximetry spot checks—at setup, around day 60, and as needed.**

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

Prescriber's address _____

Prescriber's signature _____ **Date** _____

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