VENTILATOR PRESCRIPTION & CERTIFICATE OF MEDCIAL NECESSITY

VIP Phone: 866-361-2334

VIP Fax: 888-522-6861

REQUIRED ATTACHMENTS: Patient Demographics, Insurance Card, Medical Records

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Patient Name: _____ **DOB:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Cell Phone:** _____ **Insurance:** _____

Diagnosis:

- ☐ Chronic Respiratory Failure Consequent to COPD
- ☐ Restrictive Thoracic Disease / Progressive neuromuscular disease with progressive respiratory failure.
- ☐ Neuromuscular Disease Amyotrophic lateral sclerosis (ALS)
- ☐ Neuromuscular Disease: Muscular Dystrophy
- ☐ Other Neuromuscular Disease: _____
- ☐ **Hours of use: _8-24_ Duration of need: _99**
- ☐ **Without Ventilator patient serious harm or death or succumbing to death**
- ☒ **BIPAP was tried and failed or ruled out, supporting documentation included in chart notes.**

Prescription: ☐ E0466 Non Invasive ☐ E0465 Invasive

- ☐ Pressure support ventilator with volume control mode (may include pressure control mode) to be use with non-invasive interface (e.g. Full face or nasal cushion) for nocturnal ventilation
- ☐ Pressure support ventilator with volume control mode (may include pressure control mode) to be used with oral interface (e.g. angled mouthpiece) mounted on patient's wheelchair for mobility
- ☐ Humidifier for use with stationary ventilator (E0562)
- ☐ Supplemental Oxygen entrained @_____lpm

Initial Settings:

- ☐ **Mode:** ☐ Assist / Control ☐ SIMV ☐ Pressure Control ☐ Pressure Support
- ☐ **Return Tidal Volume:** 6-7 mL/kg of ideal body weight
- ☐ **Pressure Support:** to insure return tidal volume of 6-7 mL/kg of ideal body weight
- ☐ **Night/Sleep Mode**: ST, AVAPS,VT 300-800ml; Ipap 8-25 cmh20; Epap 4-8 cmh20; rate 8-12, AVAPS AE Max pressure__ Max PS___ , Min PS , Max Epap___ , Min Epap____. BUR-Auto Rate.(Respiratory Therapist to titrate for patient's comfort)

☐ **Daytime Use:** Mouthpiece ventilation in PC mode as needed Ipap 8-15 cmh20; Epap 0-5; Rate 0-10 use during day for SOB and to increase exercise tolerance. Ipap_____ Epap_____ RR _____

☐ **Night/Sleep Mode:**

AVAPS: Ipap min:_____ Ipap max;_____ Epap/Peep:_____
AVAPS AE: Max Pressure__ Max PS____, Min PS____, Max Epap ___, Min Epap____ BUR-Auto Rate
BIPAP ST: Ipap:_____ Epap/Peep_____ Rate:_____

- ☐ **FIO2: _____%**
- Adjust inspiratory time, flow and sensitivity setting for patient comfort.
- Adjust ventilator settings as necessary to maximum comfort and therapeutic benefit.

*Follow up by Respiratory Therapist, minimum once a month to perform Vent maintenance, patient use and assessment, written follow up to prescribing Physician and Download Usage Reports

Physician Name: _____ **NPI:** _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Signature _____ Date: _____