VEST E0483 THERAPY PRESCRIPTION
MEDICAL NECESSITY & ASSESSMENT FORM

VIP Phone: 866-361-2334

VIP Fax: 888-522-6861

REQUIRED ATTACHMENTS: Patient Demographics, Insurance Card, Medical Records

General Patient Information

First Name _____ Last Name _____ Gender _____ Date of Birth _____

Email _____ Phone _____

Patient Measurements: Chest_____ (Inches) **Abdomen _____ (Inches)**

Airway Clearance Therapy TRIED AND FAILED- Documented in Patient Progress Notes

Which of the following treatment methods have been tried and ruled out?

☐ CPT (Manual or Percussor) ☐ PEP ☐ Flutter/Acapella
☐ Cough Assist ☐ Breathing/Drainage Techniques ☐ Other
If other, provide a brief description above

Check all the reasons the above treatment failed, is inappropriate, or contraindicated.

☐No Caregiver Available ☐ Physical Limitations of Caregiver ☐ Aspiration Risk/GERD
☐ Physical Limitations of Patient ☐ Did not Mobilize Secretions ☐ Artificial Airway
☐ Too Fragile for Percussion ☐ Resistance to Therapy ☐ Cognitive
☐ Can't Tolerate Positioning ☐ Insufficient Expiratory Force ☐ Other
☐ Severe Arthritis/Osteoporosis ☐ Kyphosis/Scoliosis
☐ Spasticity/Contractures ☐ Inability to Form Mouth Seal

Relevant Medical History From the Past Year

☐ Resistant Bacteria found in Sputum ☐ Decline in Pulmonary Function ☐ Mucus Plugs
☐ Physical Limitations of Patient ☐ 3+ Exacerbations Requiring Antibiotics ☐ Respiratory Infection
☐ Hospitalizations for Pulmonary Exacerbations ☐ ER Visits for Pulmonary Exacerbations ☐ Daily Productive Cough for Minimum 6 Months

If more than two exacerbations requiring antibiotics, select whether oral, intravenous, or both.
☐ IV | ☐ Oral

For bronchiectasis patients, is there a CT scan confirming bronchiectasis diagnosis?
☐ Yes | ☐ No

Rx: High Frequency Chest Wall Oscillation Device (HFCWO) HCPCS: E0483

☐ **inCourage Vest** ☐ **Afflo Vest**

Diagnosis: List all primary, secondary and underlying pulmonary, neurologic and other myopathy diagnosis that apply.

1. _____ **Code** _____ **3.** _____ **Code** _____

2. _____ **Code** _____ **4.** _____ **Code** _____

Quick Start Protocol (recommended): If Not Checked Use Recommended Protocol

☐ **Tx/Day: 2 Minutes/Tx: 30 I Frequencies : 5-15Hz I Pressure: 60-100% (or as tolerated by patient) Minimum usage/day: 10-15 minutes**

☐ **Custom Protocol (If other than recommended) Tx/Day_____ Min/Tx_____ Freq_____ Min Use/Day_____ Pressure_____**

I certify that the information contained on this form is true, accurate and complete to the best of my knowledge. This prescription is for HFCWO, which according to my professional judgment, is medically necessary for the patient listed above. The patients records contain documentation that supports use of the HFCWO therapy. I agree to provide such documentation to Pulmonary Solutions upon request. A copy of this order will be retained as part of the patient's medical record.

Check Length of Need: ☒ Lifetime (99)

Facility Name _____ Address _____ Phone _____ Fax _____

Ordering Physician Name (Please Print) _____ NPI (Required) _____

Pulmonary Solutions personnel may fill in physicians name and NPI prior to physicians signature and date.

Physicians Signature _____ Date _____