



Continuous Positive Airway Pressure (CPAP) Rental or Purchase Prior Authorization (PA) Request Form

(Incomplete Form May Delay Processing)

Table with 2 columns: Provider Information and Member Information. Rows include Ordering Physician Name, NPI #, Contact Name, Member Name, Member ID #, Vendor Name, Vendor Phone #, Vendor Fax #, Member's Date of Birth, Member's Phone #, and ICD-10 Code(s).

Please answer questions below

HCPCS code(s) (REQUIRED): _____

If this request is for an INITIAL 3-MONTH RENTAL, please provide the following information:

- 1. What is the start date of the rental?
2. Did the member have a face-to-face clinical evaluation in-person by the treating physician to assess for obstructive sleep apnea prior to the sleep test?
3. Did the member have a positive sleep test result that meets one of the following criteria?
a. The Apnea Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) is >= 15 events per hour with a minimum of 30 events?
b. The AHI or RDI is >= 5 with <=14 events per hour with a minimum of 10 events with documented symptoms of:
- Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia, OR
- Hypertension, ischemic heart disease, or history of stroke

**Note: If a or b above is not met, submit a copy of the member's relevant medical records for review.

- 4. Has the member and/or the caregiver received instruction from the vendor in the proper use and care of the equipment?

If this request is for PURCHASE after completion of a 3-month rental period, please provide the following information:

- 1. Did the member use the device at least 4 hours, 70% of a 30-day period? (This is 21 out of 30 days via a compliance chip or sleep record)?

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If no, please provide a copy of the compliance download for review.

2. Did the member have an in-person clinical re-evaluation by the treating practitioner with documentation that symptoms of obstructive sleep apnea are improved..... Yes No
3. Was objective evidence of adherence to use of the PAP device, reviewed by the treating practitioner Yes No

*Special note, If the treating practitioner re-evaluation does not occur until after the 91st day but the evaluation demonstrates that the beneficiary is benefiting from PAP therapy as defined in criteria 1 and 2 above, continued coverage of the PAP device will commence with the date of that re-evaluation.

Beneficiaries who fail the initial 12-week trial are eligible to re-qualify for a PAP device but must have both:

1. In-person clinical re-evaluation by the treating practitioner to determine the etiology of the failure to respond to PAP therapy; and,
2. Repeat sleep test in a facility-based setting (Type 1 study). This may be a repeat diagnostic, titration or split-night study.

If the member does not meet the compliance requirement above, provide the following information for review of one additional month's rental.

1. Were there extenuating circumstances which prevented the member from being compliant with use of the CPAP? Yes No
2. If yes, please list reasons (i.e. hospitalization or illness, issues with fit of mask or machine function).

3. Has the member been educated on the importance of compliance? Yes No

I certify that I have appropriate authority to request an organization determination for the item(s) indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time to verify this information.

Signature: _____ Date: _____

Please Return Completed Form to:

Fax: 1-336-794-1556

For questions, please call Care Management at 1-888-296-9790.