Use for Experience Health Medicare Advantage SM (HMO)

Bi-level Positive Airway Pressure (BIPAP) for Treatment of Breathing Related Sleep Disorders Prior Authorization (PA) Request Form

(Incomplete Form May Delay Processing)

Provider Information		Member Information
Ordering Physician Name:	NPI #:	Member Name:
Office Phone#: Office Fax#:	Contact Name:	Member ID #:
Vendor Name:	NPI #:	Member's Date of Birth:
Vendor Phone #: Vendor Fax #:	Contact Name:	Member's Phone #:
ICD-10 Code(s):		

Please answer questions below

HCPCS code(s) (REQUIRED): _____

Is this request for E0470? ……..…….. ☐ Yes ☐ No (If no, do not use this form.)

If this request is for rental of E0470, please provide the following information:

What is the start date of the rental? _ _/_ _/_ _ _ _

Are symptoms characteristic of sleep-associated hypoventilation, such as daytime hyper somnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc., documented in the member's medical record? …. ☐ Yes ☐ No

Does the member have one of the four respiratory disorders noted below? ……..…… ☐ Yes ☐ No

Complete <u>one of the following four</u> sections as applicable.

1. **Restrictive Thoracic Disorders:**
   A. Is there documentation in the member's medical record of a neuromuscular disease (for example, amyotrophic lateral sclerosis - ALS) or a severe thoracic cage abnormality (for example, post-thoracoplasty for TB)?…….. ☐ Yes ☐ No

   B. Is there documentation of one of the following?

      1. An arterial blood gas PaCO2, done while awake and breathing the member's prescribed FIO2, which is <u>≥</u> 45mmHg? …… ☐ Yes ☐ No
      2. Sleep oximetry demonstrating oxygen saturation < 88%, > 5 minutes of nocturnal recording time (minimum recording time of 2 hours) done while breathing the member's prescribed FIO2? …… ☐ Yes ☐ No
      3. For a neuromuscular disease (only), either a or b:
         a. Maximal inspiratory pressure < 60cm H2O?..…… ☐ Yes ☐ No
         b. Forced vital capacity < 50% predicted?..…… ☐ Yes ☐ No

   C. Does Chronic Obstructive Pulmonary Disease (COPD) contribute significantly to the member's pulmonary

Use for Experience Health Medicare Advantage SM (HMO)

Bi-level Positive Airway Pressure (BIPAP) for Treatment of Breathing Related Sleep Disorders Prior Authorization (PA) Request Form

(Incomplete Form May Delay Processing)

limitation?..... ☐ Yes ☐ No

2. **Severe Chronic Obstructive Pulmonary Disease (COPD):**
   A. Is the member's arterial blood gas PaCO2 ≥ 52mmHg while awake and using prescribed FIO2? ..... ☐ Yes ☐ No

   B. Does the member's sleep oximetry demonstrate oxygen saturation ≤ 88% for ≥ 5 minutes of nocturnal recording time (minimum recording time of 2 hours)? ..... ☐ Yes ☐ No

   Was the above oximetry completed while breathing oxygen at 2L/min or the member's prescribed FIO2 (whichever is higher)? ..... ☐ Yes ☐ No

   C. Was treatment with a CPAP device considered and ruled out? ..... ☐ Yes ☐ No

3. **Central sleep apnea (CSA) or complex sleep apnea (Comp SA):**
   A. Prior to initiating therapy, did the member have a monitored, facility-based sleep study which documented the following (1 and 2)?
      1. The diagnosis of central sleep apnea (CSA) or complex sleep apnea (CompSA)? ☐ Yes ☐ No
      2. Significant improvement of the sleep-associated hypoventilation with the use of an E0470 device on the settings that will be prescribed for initial use at home, while breathing the member's prescribed FIO2?..... ☐ Yes ☐ No

4. **Hypoventilation syndrome:**
   A. Was the member's initial arterial blood gas (ABG) PaCO2, completed while awake and breathing the member's prescribed FI02, ≥ 45 mm Hg? ..... ☐ Yes ☐ No

   B. Does the member's spirometry show an FEV1/FVC ≥ 70%? ..... ☐ Yes ☐ No

   C. Does the member's ABG PaCO2, completed during sleep or immediately upon awakening, and breathing his/her prescribed FIO2, show worsening PaCO2 of ≥ 7mmHg compared to the original result in question 4A above? ..... ☐ Yes ☐ No

   D. Does the facility-based PSG or HST demonstrate oxygen saturation ≤ 88% for ≥ 5 minutes of nocturnal recording time (minimum recording time of two hours) that is not caused by obstructive upper airway events (such as indicated by an AHI < 5)?..... ☐ Yes ☐ No

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

1. Does documentation in member's medical record reflect progress of relevant symptoms? ..... ☐ Yes ☐ No

2. Does the compliance chip show the member consistently uses the device at least 4 hours per 24 hours? ..... ☐ Yes ☐ No

Use for Experience Health Medicare Advantage SM (HMO)

Bi-level Positive Airway Pressure (BIPAP) for Treatment of Breathing Related Sleep Disorders Prior Authorization (PA) Request Form

(Incomplete Form May Delay Processing)

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

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 Experience Health Medicare Advantage SM (HMO) may request medical records for this patient at any time in order to verify this information.

Signature:_____ Date: _____

Please Return Completed Form to:
Fax 1-919-765-7805
For questions please call Care Management at 1-833-941-0107.

Experience Health Medicare Advantage SM is a HMO plan. This plan has a Medicare contract. Enrollment in the plan depends on contract renewal.