AFFLOVEST PRESCRIPTION AND CERTIFICATE OF MEDICAL NECESSITY

General Patient Information

First Name | Last Name | Gender | Date of Birth

Address | City | State | ZIP Code

Email | Phone | SS#

Primary Diagnosis | Code

Secondary Diagnosis | Code

Medicare ID #

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

Which of the following treatment methods have been tried and failed?

☐ 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 ☐ GERD
☐ Physical Limitations of Patient ☐ Did not Mobilize Secretions ☐ Young Age
☐ Too Fragile for Percussion ☐ Resistance to Therapy ☐ Aspiration Risk
☐ Can't Tolerate Positioning ☐ Insufficient Expiratory Force ☐ Artificial Airway
☐ Severe Arthritis/Osteoporosis ☐ Kyphosis/Scoliosis ☐ Cognitive Level
☐ Spasticity/Contractures ☐ Inability to Form Mouth Seal ☐ Other

If other, provide a brief description above

Relevant Medical History from the Past Year

☐Resistant Bacteria found in Sputum ☐ Decline in Pulmonary Function ☐ Mucus Plugs
☐ Physical Limitations of Patient ☐ 2+ Exacerbations Requiring Antibiotics ☐ Respiratory Infection
☐ Hospitalizations for Pulmonary Exacerbations ☐ ER Visits for Pulmonary Exacerbations ☐ Atelectasis

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

Comments_____

Rx: The AffloVest Airway Clearance System, HCPCS: E0483

I certify the accuracy of this Rx for the AffloVest Airway Clearance System and that I am the physician identified in this form. I certify that the medical information provided above and in the supplementary documentation is true, accurate, and completed to the best of my knowledge. The patient record contains the supplementary documentation to substantiate the medical necessity of the AffloVest and physician notes will be provided to the authorized AffloVest distributor by request. By providing this form to an authorized AffloVest distributor, I acknowledge that the patient is aware that he or she may be contacted by said distributor for any additional information to process this order.

Physician Signature (No Signature Stamp) Date

Physician's Name (Please Print) NPI Number

Email Phone Fax

Institution

Address

___Lifetime Rx ___30 Day Evaluation

Protocol – Standard or Custom

2 Treatments Per Day	Treatments Per Day
30 Minutes Per Treatment	Minutes Per Treatment
[Soft]5-20Hz[Intense] Frequencies/Intensities	Frequencies
10 Minimum Use Per Day	Minimum Use Per Day

The Right Box Takes Precedence as the Individualized Protocol, if Completed

Patient Measurements:

Chest circumference measured at nipple line in inches:_____

Stomach circumference measured at naval line in inches:_____

Torso length measured from middle of shoulder to waist/belt line in inches:_____

Height (inches):_____ Weight (lbs.):_____