JOHNS HOPKINS MEDICINE
Care at Home

PAP Dispensing Order

In addition to this Order, please fax the following to 410-282-8455:
1) Cover sheet with contact information;
2) Face-to-face and other relevant clinical notes

Johns Hopkins Pharmaquip
5901 Holabird Avenue
Baltimore, MD 21224
410-288-8969
Fax: 410-282-8455

ORDER DATE:_____

Patient Name: (Last, First)	Address: (include Zip Code)	Contact Phone:
Primary Insurance: Policy #_____	Secondary Insurance: Policy # _____	Date of Birth: ____/____/____

Diagnosis:
☐ G47.33 Obstructive Sleep Apnea
☐ G47.37 Central Sleep Apnea
☐ Other:_____
☐ G47.36 Sleep-Related Hypoventilation
☐ J44.9 COPD

Length of Need:
☐ Lifetime
☐ Other: _____

Please check the device you are prescribing:

☐ CPAP Unit w/ Humidifier Pressure: _____cm of H_2O

☐ Auto CPAP w/ Humidifier Min ___Max ___ cm of H_2O

☐ Oxygen Bleed In ____liters per minute

☐ BiLevel w/ Humidifier Pressure: ___IPAP ___EPAP

☐ Auto BiLevel w/Humidifier ___IPAP max ___EPAP min___Pressure Support

☐ BiLevel w/ Humidifier with Rate ___IPAP ___EPAP ___ Rate

☐ BiLevel ASV Auto w/ Humidifier___Min EPAP ___Max EPAP ___ Min PS ___Max PS ___Max Pressure ___Rate

☐ Oxygen Bleed In ____liters per minute

Please check the supplies you are prescribing:

Supplies

☐ Humidifier Chamber (1 every 6 months)
☐ Heated Tubing (1 every 3 months)
☐ Nasal Interface (1 every 3 months)
☐ Replacement Nasal/Pillow cushions (2 per month)
☐ Headgear (1 every 6 months)
☐ Disposable Filters (2 per month)
☐ Chin Strap (1 every 6 months)
☐ Full Face Mask Frame (1 every 3 months)
☐ Full Face Mask Cushion (1 per month)
☐ Non-Disposable Filters (1 every 6 months)
☐ Non Heated Tubing (1 every 3 months)

Medical Justification (required if prescribing a replacement machine):

Due to the above diagnosis, a Bi/CPAP Unit is required for this patient. I, the undersigned, certify that the above prescribed equipment is reasonable and necessary according to accepted standards in the treatment of this condition and is not prescribed as a convenience device. The above name patient is at risk for heart arrhythmias, high blood pressure, and other symptoms associated with Obstructive Sleep Apnea Syndrome if s/he remains untreated. Additionally, the use of this device will improve sleep architecture resulting from OSAS, as well as long term reversal of symptoms (excessive daytime sleepiness, poor concentration, forgetfulness, irritability, anxiousness, depression, falling asleep on the job or while driving). Documentation supporting the diagnosis and need for equipment is present in the medical record and is available upon request.

Authorized Prescriber:

Name:	NPI #:
Address:	
Phone:	Fax #:

Signature: "This order has been electronically signed by:

On (Date and Time)":

This form must be signed and dated by the prescribing physician before the therapy/equipment may be considered for payment. Physician's signature certified that the above represents his judgement of the patient's need for the therapy/equipment.