

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
410-288-8150
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: <input type="checkbox"/> G47.33 Obstructive Sleep Apnea <input type="checkbox"/> G47.36 Sleep-Related Hypoventilation <input type="checkbox"/> G47.37 Central Sleep Apnea <input type="checkbox"/> J44.9 COPD <input type="checkbox"/> Other: _____		Length of Need: <input type="checkbox"/> Lifetime <input type="checkbox"/> Other: _____

Please check the device you are prescribing:

<input type="checkbox"/> CPAP Unit w/ Humidifier Pressure: _____ cm of H ₂ O <input type="checkbox"/> Auto CPAP w/ Humidifier Min ____ Max ____ cm of H ₂ O <input type="checkbox"/> Oxygen Bleed In ____ liters per minute	<input type="checkbox"/> BiLevel w/ Humidifier Pressure: ___ IPAP ___ EPAP <input type="checkbox"/> Auto BiLevel w/Humidifier ___ IPAP max ___ EPAP min ___ Pressure Support <input type="checkbox"/> BiLevel w/ Humidifier with Rate ___ IPAP ___ EPAP ___ Rate <input type="checkbox"/> BiLevel ASV Auto w/ Humidifier ___ Min EPAP ___ Max EPAP ___ Min PS ___ Max PS ___ Max Pressure ___ Rate <input type="checkbox"/> Oxygen Bleed In ____ liters per minute
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Please check the supplies you are prescribing:

<u>Supplies</u>	
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)":
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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.