JOHNS HOPKINS PHARMAQUIP
PAP/BILEVEL DISPENSING ORDER

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Baltimore, MD 21224
Phone: 410-288-8969
Fax: 410-282-8455

Date of Order:

Patient Name: (Last, First)	**Address**: (include Zip Code)	**Phone Number:**
Primary Insurance: Policy:	**Secondary Insurance**: Policy:	**Date of Birth**:
Diagnosis: ☐ G47.33 Obstructive Sleep Apnea ☐ **G12.21** ALS ☐ G47.37 Central Sleep Apnea ☐ Other:		**Length of Need:** ☐ Lifetime ☐ Other: _____

CHECK APPROPRIATE BOXES TO PRESCRIBE EQUIPMENT/SUPPLIES. IF DELETING ANY SUPPLY, INDICATE AND INITIAL

PAP Prescription (please check one of the following):	**Bi Level Prescription (please check one of the following):**
☐ CPAP Unit for daily use with Nasal Interface ✓ Supplies** ✓ Heated Humidifier and/or heated tubing	☐ Bi Level for daily use with Nasal Interface ✓ Supplies** ✓ Heated Humidifier and/or heated tubing
☐ CPAP Unit for daily use with Nasal Pillows ✓ Supplies** ✓ Heated Humidifier and/or heated tubing	☐ Bi Level for daily use with Nasal Pillows ✓ Supplies** ✓ Heated Humidifier and/or heated tubing ✓
☐ CPAP Unit for daily use with Full Face Mask ✓ Supplies** ✓ Heated Humidifier and/or heated tubing	☐ Bi Level for daily use with Full Face Mask ✓ Supplies** ✓ Heated Humidifier and/or heated tubing
☐ **CPAP Pressure:** _____cmH_2O ☐ **Auto CPAP**: min_____ max_____ cmH2O ☐ **Oxygen bleed in** _____liters per minute ☐ Empiric	☐ **Bilevel Pressure:** IPAP_____ EPAP_____ ☐ **Auto BiLevel:** IPAP Max _____ EPAP Min _____ Pressure Support _____ (can be a single value or a min and max press. support value) ☐ **BiLevel with rate**: IPAP_____ EPAP_____ Rate _____ ☐ **Bilevel ASV Auto**: Min EPAP_____ Max EPAP_____ Min PS_____ Max PS_____ Max Pressure_____ Rate_____ ☐ **Oxygen bleed in** _____liters per minute

****Supplies:** SUPPLIES INCLUDE, BUT ARE NOT LIMITED TO THE FOLLOWING: HUMIDIFIER CHAMBER, FILTERS, CHIN STRAP, HEADGEAR AND MASK INTERFACE. REPLACEMENT SUPPLIES WILL BE PROVIDED AS INDICATED AND NECESSARY.

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.

Medical Justification, if replacement machine:

Authorized Prescriber:

Name:	**NPI #**
Address:	
Phone:	**Fax #:**
Signature:	**Date:**