Complete and print.

Reset Form

MAYO CLINIC

Positive Airway Pressure Prescription

Mayo Clinic Store

Form content not retained in medical record.
Route to Mayo Clinic Store for electronic storage.

(complete fields or place patient label here)

Patient Name *(First, Middle, Last)*
Birth Date *(mm-dd-yyyy)*
Mayo Clinic or Store Account Number

External Form Users: Complete this document and fax to the Mayo Clinic Store.
Internal Epic Downtime Form Users: Complete this document and fax to the Mayo Clinic Store. Once Epic downtime processes are complete, reenter order into the EHR and send an Epic message to the Mayo Clinic Store's inbasket pool informing them that a duplicated order was created.
Required: Attach patient's current primary, secondary, and tertiary insurance providers and provider-signed clinical documentation verifying medical justification from face-to-face examination. In addition, the PSG/HST and signed interpretation is required to be sent for billing.

Order Information

☐ Initial ☐ Pressure change
☐ Renewal ☐ Supplies only

Order Date *(mm-dd-yyyy)*

Start Date *(mm-dd-yyyy)*

Need Length
☐ Lifetime ☐ Other_____

Qualifying Diagnosis (ICD-10)
- ☐ Central sleep apnea (G47.31)
- ☐ Obstructive sleep apnea (G47.33)
- ☐ Sleep-related hypoventilation hypoxemia (G47.36)
- ☐ COPD (J44.9)
- ☐ Secondary diagnosis _____
- ☐ Restrictive thoracic disorders (ICD-10) _____

Apnea-Hypopnea Index (AHI)

Qualifying Study
- ☐ Home sleep study
- ☐ Facility-based polysomnogram

Patient Address *(Street, City, State, ZIP Code)*

Patient Phone

Supplies

- ☐ Dispense 3 month supply
- ☐ Mask, one every 3 months
  - Select one: ☐ Full face (A7030) ☐ Nasal (A7034) ☐ Nasal pillow (A7034)
- ☐ Tubing, one every 3 months
  - Select one: ☐ Heated (A4604) ☐ Non-heated (A7037)
- ☐ Cushion
  - Select one: ☐ Full face cushion, one per month (A7031) ☐ Nasal cushion (A7032), two per month ☐ Pillows (A7033), two per month
- ☐ Mask frame, one every 3 months (E1399)
- ☐ Headgear, one every 6 months (A7035)
- ☐ Reusable filter, one every 6 months (A7039)
- ☐ Disposable filter, two every month (A7038)
- ☐ Chin strap, one every 6 months (A7036)
- ☐ Humidifier chamber, one every 6 months (A7046)

Special Instructions _____

Device and Settings

CPAP Therapy E601

☐ CPAP
Pressure _____ cm H_2O (4–20 cwp)
Pressure relief? ☐ Yes ☐ No Ramp? ☐ Yes ☐ No
Humidification (E0562)? ☐ Yes

☐ Auto CPAP
Min. auto CPAP pressure _____ cm H_2O (4–20 cwp)
Max. auto CPAP pressure _____ cm H_2O (4–20 cwp)
Pressure relief? ☐ Yes ☐ No Ramp? ☐ Yes ☐ No
Humidification (E0562)? ☐ Yes

Bilevel Therapy E0470

☐ Bilevels
IPAP pressure _____ cm H_2O (4–25 cwp)
EPAP pressure _____ cm H_2O (4–25 cwp)
Pressure relief? ☐ Yes ☐ No Ramp? ☐ Yes ☐ No
Humidification (E0562)? ☐ Yes

☐ Auto Bilevel
Max. IPAP pressure _____ cm H_2O (6–25 cwp)
Min. EPAP pressure _____ cm H_2O (4–25 cwp)
Max. pressure support _____ cm H_2O (3–10 cwp)
Humidification (E0562)? ☐ Yes Ramp? ☐ Yes ☐ No

Bilevel with Back-up Rate Therapy E0471

☐ Spontaneous/timed mode (ST)
IPAP pressure _____ cm H_2O (4–25 cwp)
EPAP pressure _____ cm H_2O (4–25 cwp)
Rate _____ BPM (5–50 BPM)
Inspiratory time _____ sec.
Ramp? ☐ Yes ☐ No
Humidification (E0562)? ☐ Yes

☐ ST-A device E0471

Mode ☐ T ☐ PC
IPAP _____ cm H_2O (4–25 cwp)
IPAP _____ cm H_2O (4–30 cwp)
EPAP _____ cm H_2O (4–25 cwp)
Rate _____ cm BPM (5–50)
Inspiratory time _____ sec. (0.1–4 sec.)
Humidification (E0562)? ☐ Yes

☐ IVAPS

Height _____ inches (44–100)
Target patient rate _____ BPM (8–30 BPM)
Target Va _____ L/minute (1–30 L/minute)
Tidal volume _____ (mL)
Tidal volume/kg _____ mL/kg
EPAP _____ cm H_2O (3–25 cwp)
Min. PS _____ cm H_2O (0–20 cwp)
Max. PS _____ cm H_2O (0–24 cwp)
Humidification (E0562)? ☐ Yes

Bilevel ASV E0471

EPAP _____ cm H_2O (4 –15 cwp)
EPAP min. _____ cm H_2O (4 –15 cwp)
EPAP max. _____ cm H_2O (4 –15 cwp)
Min. PS _____ cm H_2O (0 –6 cwp)
Max. PS _____ cm H_2O (5–20 cwp)
Ramp time _____ min(s) (off–45 mins.)

Back-up rate:
Automatic (15 BPM)
(off, auto)

RAD qualifications that must be met to bill insurance: Yes
- Failed CPAP? ☐
- AHI greater than 5/hour? ☐
- Is % of central apneas greater than 50% of total? ☐
- Are central apneas/hypopneas 5/hour or greater? ☐
- Humidification (E0562)? ☐

Referring Provider Information and Signature

Facility	Phone	Fax

Provider Signature ▶ Signature Required	Provider Printed Name *(First, Middle, Last)*	Date *(mm-dd-yyyy)*	National Provider Identifier

ENTERPRISE: Applies to Mayo Clinic locations in Arizona, Florida, Rochester and Mayo Clinic Health System.

Print

MC1234-183