



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 Mayo Clinic Store.

Internal Epic Downtime Form Users: Complete this document and fax to 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

<input type="checkbox"/> Initial <input type="checkbox"/> RePAP	<input type="checkbox"/> Pressure change <input type="checkbox"/> Supplies only	Order Date (mm-dd-yyyy)	Need Length <input type="checkbox"/> Lifetime <input type="checkbox"/> Other _____
Qualifying Diagnosis (ICD-10) <input type="checkbox"/> Central sleep apnea (G47.31) <input type="checkbox"/> Obstructive sleep apnea (G47.33) <input type="checkbox"/> Sleep-related hypoventilation hypoxemia (G47.36) <input type="checkbox"/> COPD (J44.9)		<input type="checkbox"/> Secondary diagnosis _____ <input type="checkbox"/> Restrictive thoracic disorders (ICD-10) _____	
Patient Address (Street, City, State, ZIP Code)			Patient Phone

Supplies

<input type="checkbox"/> Dispense 3 month supply <input type="checkbox"/> Mask, 1 every 3 months <input type="checkbox"/> Full face (A7030) <input type="checkbox"/> Nasal (A7034) <input type="checkbox"/> Nasal pillow (A7034) <input type="checkbox"/> Tubing, 1 every 3 months <input type="checkbox"/> Heated (A4604) <input type="checkbox"/> Non-heated (A7037)	<input type="checkbox"/> Cushion <input type="checkbox"/> Full face cushion, 1 per month (A7031) <input type="checkbox"/> Nasal cushion (A7032), 2 per month <input type="checkbox"/> Pillows (A7033), 2 per month <input type="checkbox"/> Humidification (E0562) Special Instructions _____	<input type="checkbox"/> Headgear, 1 every 6 months (A7035) <input type="checkbox"/> Reusable filter, 1 every 6 months (A7039) <input type="checkbox"/> Disposable filter, 2 every month (A7038) <input type="checkbox"/> Chin strap, 1 every 6 months (A7036) <input type="checkbox"/> Humidifier chamber, 1 every 6 months (A7046)
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Device and Settings

CPAP Therapy E0601 <input type="checkbox"/> CPAP Pressure _____ cm H ₂ O (4-20 cwp) Pressure relief? <input type="checkbox"/> Yes <input type="checkbox"/> No Ramp? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Auto CPAP Min. auto CPAP pressure _____ cm H ₂ O (4-20 cwp) Max. auto CPAP pressure _____ cm H ₂ O (4-20 cwp) Pressure relief? <input type="checkbox"/> Yes <input type="checkbox"/> No Ramp? <input type="checkbox"/> Yes <input type="checkbox"/> No		Bilevel Therapy E0470 <input type="checkbox"/> Bilevels IPAP pressure _____ cm H ₂ O (4-25 cwp) EPAP pressure _____ cm H ₂ O (4-25 cwp) Pressure relief? <input type="checkbox"/> Yes <input type="checkbox"/> No Ramp? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Auto Bilevel Max. IPAP pressure _____ cm H ₂ O (6-25 cwp) Min. EPAP pressure _____ cm H ₂ O (4-25 cwp) Max. pressure support _____ cm H ₂ O (3-10 cwp) Ramp? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bilevel with Back-up Rate Therapy E0471 <input type="checkbox"/> Spontaneous/timed mode (ST) IPAP pressure _____ cm H ₂ O (4-25 cwp) EPAP pressure _____ cm H ₂ O (4-25 cwp) Rate _____ BPM (5-50 BPM) Inspiratory time _____ sec. Ramp? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> ST-A device E0471 Mode <input type="checkbox"/> T <input type="checkbox"/> PC IPAP _____ cm H ₂ O (4-25 cwp) IPAP _____ cm H ₂ O (4-30 cwp) EPAP _____ cm H ₂ O (4-25 cwp) Rate _____ cm BPM (5-50) Inspiratory time _____ sec. (0.1-4 sec.)	
<input type="checkbox"/> 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 ₂ O (3-25 cwp) Min. PS _____ cm H ₂ O (0-20 cwp) Max. PS _____ cm H ₂ O (0-24 cwp)		<input type="checkbox"/> Bilevel ASV E0471 EPAP _____ cm H ₂ O (4-15 cwp) Back-up rate: Automatic (15 BPM) (off, auto) EPAP min. _____ cm H ₂ O (4-15 cwp) EPAP max. _____ cm H ₂ O (4-15 cwp) Min. PS _____ cm H ₂ O (0-6 cwp) Max. PS _____ cm H ₂ O (5-20 cwp) Ramp time _____ min(s) (off-45 mins.)	

Referring Provider Information and Signature

Facility	Phone	Fax
Provider Signature	Provider Printed Name (First Middle Last)	Date (mm-dd-yyyy) NPI