



PRESCRIPTION WRITTEN OR VERBAL ORDER FOR NON-INVASIVE VENTILATION

Please Fax To: (916) 488-2727

Patient Name: _____ DOB: _____ Date: _____

Address: _____

Home Phone: _____ Other: _____

Diagnosis: COPD Chronic Respiratory Failure Other Pulmonary Insufficiency _____

Equipment Description:

Length of Need: _____ (12 months=1 year or 99=Lifetime)

Pressure Support Vent Non-INV Interface (E0466)

Ventilator to treat severe COPD with respiratory failure resulting in life threatening acute exacerbation:

Evo/Trilogy Settings:

AVAPS AE: Primary Settings Secondary Settings

Target VT: _____ Max Pressure: _____

Backup Rate: _____ EPAP Min: _____ EPAP Max: _____ IPAP Min: _____ IPAP Max: _____

Astral Settings:

iVAPS: Primary Settings Secondary Settings

Mode _____ Target VT: _____ EPAP Min _____ EPAP Max _____ Rate _____

Pressure Support(Min/Max) _____

MOUTH PIECE VENTILATION in PC mode as needed:

IPAP 8-15 cm H2O Other _____

EPAP 0- 5 (Rate 0 during day for SOB and to increase exercise tolerance)

Utilize enabled nebulizer to more effectively deliver aerosol medications

Nasal Interface (A7034 and A7035) Full Face Mask Interface (A7030 and A7035)

Documentation of Medical Necessity in Progress Notes

ALL RESPIRATORY ASSISTED DEVICES HAVE BEEN CONSIDERED. HOWEVER, PATIENT CANNOT MEET ADL'S DUE TO SEVERE COPD AND RESPIRATORY FAILURE AND REQUIRES TRILOGY 100 WITH SIP VENTILATION TO MEET DAILY LIVING REQUIREMENTS.

BY SIGNING BELOW, I AUTHORIZE the use of this document as a legal prescription and I certify that the above prescribed equipment is medically necessary and reasonable, and is NOT being prescribed for convenience. I will maintain an original signed copy of this record in my medical records and make it available to Medicare, its authorized agents or other insurers, if required.

Physician Name: _____

Address: _____

License: _____ NPI: _____

Telephone: _____ Fax: _____

Physician Signature: _____ Date: _____