**Non-invasive Airway Assistance Devices—Prior Authorization Form**

**(CPAP, BIPAP, AutoPAP)**

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| **Member Information** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth:  | Medicaid ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ICD-10 Diagnosis Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Requesting Provider Information** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicaid Provider #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Provider NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Provider Taxonomy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *\*Provide* ***both*** *NPI and taxonomy if Medicaid Provider # is unknown.*  |
| Date of Request:  | Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Office Contact Person Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Office Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Supplying Vendor Information** |
| Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Medicaid Provider #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Provider NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Provider Taxonomy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| *\*Provide* ***both*** *NPI and taxonomy if Medicaid Provider # is unknown.*  |
| Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Contact Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Clinical Information** |
| Type of Request: [ ]  CPAP [ ]  Bi-PAP [ ]  AutoPAP  | HCPCS Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Initial Appt Date with Sleep Provider:  | Polysomnogram Date:  |
| AHI: \_\_\_\_\_\_\_\_\_\_\_ | Oxygen Saturation: Minimum: \_\_\_\_\_\_\_\_\_\_\_ Average: \_\_\_\_\_\_\_\_\_\_\_\_ |
| PAP Titration Study Date:  | Titrated Using: [ ]  CPAP [ ]  Bi-PAP [ ]  AutoPAP  |
| Initiation of PAP Therapy Date:  | Follow Up Appt with Sleep Provider Date:  |
| Was the clinical reevaluation done no sooner than the 31st day but no later than the 91st day? [ ] Yes [ ] No  |
| Symptoms of obstructive sleep apnea improved with PAP therapy: [ ] Yes [ ] No |
| Percentage of time utilized for four (4) or more hours in a consecutive 90-day time period : Month 1: \_\_\_\_\_\_\_\_\_\_\_\_ Month 2: \_\_\_\_\_\_\_\_\_\_\_\_ Month 3: \_\_\_\_\_\_\_\_\_\_\_\_  |
| ***Rental Coverage Extension (complete if applicable)*** |
| Requested length of time for coverage extension: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Reason for continued rental needed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Equipment Replacement (complete if applicable)****Note: For equipment older than 5 years, a face-to-face evaluation by a sleep medicine or pulmonary medicine treating MD is required, documenting that the beneficiary continues to use and benefit from the PAP device.* |
| Date equipment initially received:  | Reason for replacement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Therapy Conversion (complete if applicable)*** |
|  [ ]  CPAP to Bi-PAP [ ]  Bi-PAP to CPAP [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_ |
| Reason for therapy conversion? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Note: To be considered for continued use, adherence to therapy is defined as use greater than or equal to four (4) hours per

night for a minimum of 21 nights (70% of nights) during a consecutive thirty (30) day period anytime during the first three (3)

months of initial usage. No prior authorization is required for the first three (3) month rental. All PAP therapy following this three-month time period must be prior authorized and should be submitted on this form.