**FACILITY BASED SLEEP STUDY PRIOR AUTHORIZATION REQUEST FORM**

This Request Form must be completed in its entirety for all facility-based sleep testing procedures

The DVHA will accept sleep test results within the last 3 years for Positive Airway Pressure Therapy

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

May be ordering or prescribing physician information.

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician NPI: \_\_\_\_\_\_\_\_\_\_\_\_ Medicaid Provider Number: \_\_\_\_\_\_\_\_\_\_\_\_

Physician Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician Fax#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BMI: \_\_\_\_\_\_\_\_ Epworth Sleepiness Score: \_\_\_\_\_\_\_\_\_\_\_\_ Pretest Probability: \_\_\_\_\_\_\_\_\_\_\_\_

Is this a request for a repeat study?  Yes  No If yes, date of last study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Repeat Study Indication:  Change in BMI >10%  Recent T/A or UPP  Access efficacy of oral appliance  New Symptoms

PAP Titration  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adherence to prescribed treatment  Yes  No

1. Date Study Requested: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Diagnosis Code(s)\_\_\_\_\_\_\_\_\_\_ CPT Code(s):\_\_\_\_\_\_\_\_\_\_\_\_\_

**If a polysomnography is requested, and patient qualifies for a home sleep study may the home study be substituted?  Yes  No**

**If no, document rationale: ­­­­­­­­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If a polysomnography with initiation of PAP therapy is requested, may Auto-titrating PAP be substituted?  Yes  No**

**If no, document rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is request originating from a Sleep Facility  Yes  No

Sleep Facility Name: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid Provider #: \_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Clinical Information – check all that apply (submitted documentation must include medications, along with the assessment and plan):

Co-morbid conditions:

Unexplained Pulmonary Hypertension Uncontrolled CHF (class III or IV)  COPD Stage II, III, or IV

Uncontrolled Significant, Persistent Cardiac Arrhythmia  Suspected Nocturnal Seizures

Neuromuscular Weakness and Impaired Respiratory Function  Pregnancy > than 20 weeks

Neurodegenerative Disorders  Cognitive Impairment Preventing HSAT

Disruptive Sleep Behavior Suspicious of REM Disorder  Non-ambulatory individual

Suspected Narcolepsy  Insomnia

TBI  Stroke  Chronic Opioid Treatment

1. PA **is not** required for pediatric members who are less than 18 years of age and the provider follows the Pediatric Guidelines set forth by the American Academy of Sleep Medicine.
2. Please review DVHA criteria for a HSAT at <https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/procedure-criteria>. Facility-based testing may be more appropriate.