**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#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_ 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 >5% [ ]  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: \_\_\_\_\_\_\_\_\_\_\_\_\_ CPT Code:\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.