**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.