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

**(CPAP, BIPAP, AutoPAP)**

**BENEFICIARY INFORMATION**

Name: Click or tap here to enter text. Diagnosis: Click or tap here to enter text. ICD-10 Diagnosis Code: Enter text here.

Medicaid ID #: Click or tap here to enter text. DOB: Click or tap to enter a date.

**REQUESTING PROVIDER INFORMATION**

Name: Click or tap here to enter text.Medicaid Provider #: Click or tap here to enter text.

Date of Request: Click or tap to enter a date. Phone#: Click or tap here to enter text. Fax#: Enter text here.

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Contact: Click or tap here to enter text.

**SUPPLYING VENDOR INFORMATION**

Company Name: Click or tap here to enter text.Medicaid Provider #:Enter text here. Fax #: ­­­­Enter text here.

Phone #:Click or tap here to enter text. Contact: Click or tap here to enter text.

**TYPE OF REQUEST**: CPAP Bi-PAP  AutoPAP HCPCS code: Enter text here.

Initial appointment with Sleep MD: Click or tap to enter a date. Polysomnogram date: Click or tap to enter a date.

AHI: Enter text here. Oxygen saturation: minimum Enter text here. average Enter text here.

PAP titration study date: Click or tap to enter a date. Titrated using:  CPAP  BI-PAP  AutoPAP

Initiation of PAP therapy date: Enter a date here. Follow up appt with Sleep MD date: Enter a date here.

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 has 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: Enter text here. Month 2: Enter text here. Month 3: Enter text here.

Coverage requested beyond initial three (3) month trial Requested rental length: Click or tap here to enter text.

Reason for continued rental: Click or tap here to enter text.

Cause for replacement:Click or tap here to enter text. Date equipment initially received: Click or tap here to enter text.

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.

Conversion If yes, check appropriate box CPAP to Bi-PAP Bi-PAP to CPAP Other:Click or tap here to enter text.

What is the reason for conversion? Click or tap here to enter text.

**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.**