NON-INVASIVE VENTILATOR

Phone: (219) 795-1296 Fax: (219) 795-1349
www.lifedme.com • info@lifedme.com

Trilogy 100/200 NIV

Diagnosis Qualifications

<table>
<tr><th>Chronic Respiratory Failure</th><th>Advanced Neuromuscular Disease</th><th>Thoracic Restrictive Syndrome</th></tr>
<tr><td>History of Chronic respiratory failure subsequent to chronic obstructive pulmonary disease</td><td>Documentation of disease impact on patient’s inability to participate in ADLs</td><td>Musculoskeletal disorder documentation of FVC found to be below 50% predicted.</td></tr>
<tr><td rowspan="2">• Multiple hospital admissions previous 6 months
• $pCO_2 \geq 52$mmHg; or FEV1 < 50% and an FEV1/FVC < 70% predicted
• ABG done while awake and on prescribed FIO_2
• $ETCO_2 \geq 48$mmHg for 5 minutes or more during a test lasting at least 2 hours
• OSA and CPAP has been ruled out
• RAD with or without back-up rate has been tried and failed or found to be ineffective</td><td rowspan="2">Patient respiratory mechanics are found to be 50% or more below predicted values</td><td>Patient’s respiratory status has been significantly impaired, PaCO2 Level at or above 45mmHG</td></tr>
<tr><td>Morbid Obesity</td></tr>
</table>

<u>PLEASE INCLUDE ALL OF THE FOLLOWING REQUIRED DOCUMENTATION</u>

- Copy of patient demographics and insurance information
- Face-to-Face patient evaluation/hospital medical records within last 6 months, showing above NIV qualifications.
- Reason for medical necessity, including why the patient needs pressure support ventilation due to severe and/or life threatening disease state, and the consequences if the patient does not receive the benefit of pressure support ventilation.

Non-Invasive Pressure Support Ventilator

Fax Completed Order Form : (219) 795-1349
Contact for Support: (219) 795-1296
www.lifedme.com • info@lifedme.com

PHYSICIAN'S ORDER FORM

Patient Information

Patient Name:	Patient DOB:
Order Date:	Phone:

EQUIPMENT PRESCRIBED

NON-INVASIVE PRESSURE SUPPORT VENTILATION, E0466

❑ Chronic Respiratory Failure (J96.10) ❑ COPD (J44.9) ❑ Other_____________

Trilogy Non-Invasive Ventilator

Modes: ❑AVAPS AE

Settings (Suggested):

PS Min: __________ (4CM Above EPAP Min)
EPAP Min: __________ (5 CM)
PS Max: __________ (25 CM)
EPAP Max: __________ (15 CM)
MAX PRESSURE: __________ (Max of 50CM)
Inspiratory Time: __________ ❑ (.8 – 1.5)
Rate: ❑ AUTO (Preferred) or _________
Tidal Volume: _________ or ❑ (6-8cc/kg IBW)

Astral Non-Invasive Ventilator

Modes: ❑ iVaps

Patient Height _______ (IN)
EPAP Min ________ (5 CM)
EPAP Max __________ (15 CM)
PS Min ___________ (7-9 CM)
PS Max _________ (20-25 CM Up to 40 CM)
Breath Rate _________ (Spontaneous, ≥ 15)
Target Tidal Volume _________ (6-8 cc/KG IBW)

❑ Hours of Use: During Sleep & PRN
(Unless Indicated) ____________
❑ Mask Interface: Fit to Comfort
(Unless Indicated) ____________
❑ Humidity: Set to Comfort
(Unless Indicated) ____________
Length of Need: ❑ Lifetime – 99 Months
❑ Other __________

Supplemental Oxygen: ❑ Titrate o2 to maintain SaO2> _______ ❑ FiO2/lpm,

Additional Comments: ____

PHYSICIAN INFORMATION

Physician's Name: __________________________ Date: ____________________________________

Physician's Signature: _______________________ NPI: ____________________________________