



Non-Invasive Ventilator Written Order

Fax: 602-428-6841

Phone: 480-795-7955

Orders@MyTritonSupply.com

Patient Name: _____ Phone #: _____

Address: _____

Ins ID#: _____ Patient DOB: _____ Sex: ☐ Male ☐ Female

Refer to coverage criteria sheet for all required documentation.

Length of Need (# of months) _____ 1-99 (99=lifetime) Date of Last Visit: _____

Diagnosis:

- | | |
|--|--|
| ☐ Chronic Respiratory Failure (J96.10) | ☐ ALS (G12.21) |
| ☐ Chronic Respiratory Failure w/ Hypoxia (J96.11) | ☐ Multiple Sclerosis (G35) |
| ☐ Chronic Respiratory Failure w/ Hypercapnia (J96.12) | ☐ Myasthenia Gravis (G70.00) |
| ☐ Acute/Chronic Resp. Failure (J96.20) | ☐ Muscular Dystrophy (G71.00) |
| ☐ Acute/Chronic Resp. Failure w/ Hypoxia (J96.21) | ☐ Paraplegia (82.20) |
| ☐ Acute/Chronic Resp. Failure w/Hypercapnia (J96.22) | ☐ Quadriplegia (G82.50) |
| Consequent to: ☐ COPD (J44.9) | ☐ Other: _____ |
| ☐ Sarcoidosis (D86.9) | |
| ☐ Obesity Hypoventilation Syndrome (E66.2) | ☐ Unspecified kyphosis, thoracic region (M40.204) |
| ☐ Pulmonary Fibrosis (J84.10) | ☐ Musculoskeletal Deformities (M95.9) |
| ☐ Interstitial Lung Disease (J84.9) | ☐ Other: _____ |

HIV SETTINGS & SUPPLIES:

- ☐ Non-Invasive Ventilator (HCPCS E0466)

Primary Settings:

☐ Volume Assured Pressure Support
Max Pressure _____ PS Min _____ PS Max _____
EPAP Min _____ EPAP Max _____ Vt _____

Additional Info:

☐ Respiratory Therapist to titrate pressures and/or adjust Vt for optimal therapy and patient comfort.

Supplies:

- ☐ Heated Humidifier (A9999)
☐ Disposable H2O Chamber – 4/month (A9999)
☐ Reusable Ventilator Circuit – 1 every 3 months (A9900/A9999)
☐ Bacteria Filters – 4/month (A9999)
☐ PRN Filters: Air/Intake Filter 1/6 months Particulate Filter 1/month
White Pollen Filter 2/month Fan Filter 1/6 months

Secondary Settings:

- ☐ Assist Control via Mouthpiece ventilation Vt _____
☐ Pressure Control via Mouthpiece Ventilation
IPAP _____ EPAP _____

Frequency & Usage:

- ☐ Continuous ☐ Nocturnal ☐ PRN
☐ Supplemental Oxygen Bleed In
☐ Sterile H2O – 31,000mL max/mo (A4217)
☐ Non-Invasive Interface (Patient Preference)
Full Face Mask (A7030) – 1 every 3 months
Full Face Cushion (A7031) – 1/month
Nasal Mask (A7034) – 1 every 3 months
Nasal Pillows/Cushions (A7032/A7022) – 2/month
☐ MPV Circuit – 4/month (A4618)

Provider Certification:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature: _____ Date: _____ NPI: _____

Providers Name: _____ Telephone: _____