The Vest APX System Prescription/Order Form

Offered by Advanced Respiratory Inc., a Baxter Company, 1020 West County Road F, St. Paul, MN 55126, Phone: 1.800.426.4224 www.baxter.com

REQUIRED ATTACHMENTS: patient demographics, copy of insurance card, medical records, and face to face encounter documents

Patient Name: _____
(Required - please print) **First** **Middle** **Last**

Birth Date: ____ / ____ / ____ Gender: ☐ M ☐ F Primary Language: _____

_____
Street City State Zip

Chest Circumference: _____
Height: _____
Weight: _____
Garment Type: ☐ Vest ☐ Wrap
Size/Color: _____

Primary Insurance & ID#: _____ Secondary Insurance & ID#: _____

Patient Contact Name: _____ Relationship to Patient: _____

Phone: _____ ☐ H ☐ C ☐ W Alt Phone: _____ ☐ H ☐ C ☐ W E-mail: _____

Following Physician/PCP: _____ Phone: _____ E -mail: _____

Facility Contact: _____ Phone: _____ E -mail: _____

Date patient last seen: _____ Is the patient currently in the hospital? ☐ N ☐ Y Discharge Date: _____

BELOW THIS LINE TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY

(The prescriber must initial and date any revisions made after the prescriber has signed the order form)

Please provide supporting documentation for all checked boxes.

Please indicate methods of airway clearance patient has tried and failed (check all that apply):

☐ CPT (manual or percussor) ☐ Oscillating PEP ☐ PEP ☐ Cannot use other methods ☐ Other

Check all reasons why therapy failed, or is contraindicated or inappropriate for this patient:

☐ Unable to tolerate therapy ☐ Aspiration risk ☐ Physical limitations of caregiver/lack of caregiver ☐ Other

Medical history in the past 12 months, unless otherwise indicated (check all that apply):

☐ 3 or more exacerbations requiring antibiotics ☐ Daily productive cough for at least 6 months

Complete for Bronchiectasis patients:

☐ CT Scan confirming diagnosis **OR** ☐ Statement in Medical Record (i.e., "CT on 1/1/09 confirms Bronchiectasis")

Please check box if patient nebulizer therapy is to be used in conjunction with HFCWO: ☐

Clinic Information: Fac#

Phone: Fax:

1. _____
Signature Date (Required - MM/DD/YY)

2. _____
Prescriber's Signature (Required - no stamped signatures accepted)

3. _____
Print Prescriber's First and Last Name (Required)

4. _____
NPI Number (Required)

Please include documentation of a Face to Face encounter with the patient for a medical condition that supports the need for the device. This is required before device shipment.

Rx Item: High Frequency Chest Wall Oscillation (HFCWO) Device E0483

Primary Diagnosis _____

Primary Diagnosis Code _____

Secondary Diagnosis _____

Secondary Diagnosis Code _____

PROTOCOL

Please Note: The Standard Protocol is used if any or all sections of the Custom Protocol are left blank.

	Standard	Custom
Treatments per Day	2	
Minutes per Treatment	10-30	
Frequencies	6-20	
Minimum Minutes of Use per Day	10	
Length of Need	99 months = Lifetime	

Other Protocol Notes:

*Unless otherwise stated, settings titrated to accommodate patient efficacy and comfort.

Fax to 1.800.870.8452 with face sheet, copy of insurance card, and medical records

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Baxter

ORDERING GUIDE CHECKLIST

FAX WITH APPLICABLE RECORDS TO: **800-870-8452**

The following items are a guide to the general requirements of each product category. Actual requirements vary by insurance – additional requirements may be requested.

Local Baxter Representative: _____

Phone: _____

Email: _____

- ☐ Physician Standard Written Order including patient name, description/name of item being ordered, physician printed name or NPI, and physician signature and date
- ☐ Patient demographic/face sheet, copy of patient's insurance card, and the applicable required supporting documentation for the equipment being ordered as outlined below

	HIGH FREQUENCY CHEST WALL OSCILLATION (HFCWO) **The Vest** airway clearance system **Monarch** airway clearance system	OSCILLATION AND LUNG EXPANSION (OLE) **Volara** system	MECHANICAL IN-EXSUFFLATION (MIE) **Synclara** cough system	NONINVASIVE VENTILATION (NIV) **Life2000** ventilation system
MEDICAL RECORDS	☐ Past 6-12 months including: ☐ Clinic visit notes ☐ Hospitalizations/discharge summaries ☐ Antibiotics and medications ☐ Pulmonary function tests (PFT'S) ☐ Daily productive cough for at least six continuous months or three or more exacerbations within the past year requiring antibiotics ☐ Other airway clearance tried and/or considered and reasons why other therapies were inappropriate, contraindicated, or failed			☐ Past 3-6 months including: ☐ Clinic visit notes ☐ Hospitalizations/discharge summaries ☐ Respiratory therapy/pulmonary rehab notes ☐ Pulmonary function tests (PFT'S) ☐ Blood gas reports ☐ Bilevel therapy tried and/or considered and reasons why other therapies were inappropriate, contraindicated, or failed
IMAGING	☐ Medical imaging reports of the lungs including CT scans, x-ray, and bronchoscopy (as applicable) ☐ For bronchiectasis patients, include CT scan confirming diagnosis, or if unavailable, statement in the medical records			
OTHER	☐ Face-to-face encounter with the patient within the last 6 months documenting the medical need for the product (as applicable)	☐ If patient already has other airway clearance/ respiratory therapies, include the reason why the patient needs the **Volara** system in addition to their current regimen	☐ Face-to-face encounter with the patient within the last 6 months documenting the medical need for the product (as applicable)	☐ If patient already has a non-invasive ventilator, include the reason why the patient needs the **Life2000** ventilation system in addition to their current regimen

Contact your Baxter Respiratory Health Sales Representative or Baxter Customer Service at **1-800-426-4224** if you have any questions.

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