Sleeptopia
DON'T IGNORE THE SNORE®

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FOR PRESCRIBING PROVIDERS

Medical Prescription & Treatment Order

Fax to (888) 510-0314

Patient Information

FIRST NAME	LAST NAME	MI	SUFFIX	GENDER	DATE OF BIRTH (MM/DD/YYYY)

Diagnosis

Length of need: 99 years = lifetime

Primary diagnosis: **Obstructive sleep apnea (G47.33)** *Also:* ☐ Nocturnal hypoxemia (G47.36) ☐ Other _____

PAP Therapy

Select one

- ☐ **Auto CPAP** E0601 — Min 5 Max 20 cmH_2O · Ramp 30 min
- ☐ **CPAP** E0601 — Pressure _____ cmH_2O · Ramp _____ min
- ☐ **Auto BiPAP** E0470 — Max IPAP _____ Min EPAP _____ PS _____ cmH_2O · Ramp _____ min
  - ☐ or standard settings: Max IPAP 15 · Min EPAP 5 · PS 4
- ☐ **BiPAP** E0470 — IPAP _____ EPAP _____ cmH_2O

Oxygen

If prescribed

- ☐ _____ liters of nocturnal oxygen bled into PAP therapy
- ☐ _____ liters of nocturnal oxygen by nasal cannula
- ☐ ONO on CPAP

Primary diagnosis for oxygen: R09.02 hypoxia/hypoxemia.

Sleep Supplies

Replacement frequencies follow the schedule shown

☐ **All related sleep supplies**, including but not limited to those below. Fit to patient comfort. *or select items*

	HCPCS	ITEM	FREQUENCY
☐	—	Mask, fit for patient comfort	1 per 90 days
☐	E0562	Heated humidifier	—
☐	A9279	Monitoring device (modem)	—
☐	A7028	Oral/mouth cushion, combination mask	2 per 30 days
☐	A7029	Nasal pillows, combination mask	2 per 30 days
☐	A7030	Full face mask	1 per 90 days
☐	A7031	Full face cushion	1 per 30 days
☐	A7032	Nasal cushion	2 per 30 days
☐	A7033	Nasal pillows	2 per 30 days

	HCPCS	ITEM	FREQUENCY
☐	A7034	Nasal / pillow mask	1 per 90 days
☐	A7035	Headgear	1 per 180 days
☐	A7036	Chinstrap	1 per 180 days
☐	A7037	Tubing	1 per 90 days
☐	A7038	Filters, disposable	2 per 30 days
☐	A7039	Filters, non-disposable	1 per 180 days
☐	A4604	Climate Line tubing	1 per 90 days
☐	A7046	Water chamber	1 per 180 days

Physician Authorization

I am prescribing the therapy and/or supplies above for the treatment of sleep-disordered breathing. **Dispense as checked/written.**

PHYSICIAN NAME (FIRST & LAST) _____ NPI *(optional)* _____

PHYSICIAN SIGNATURE _____ DATE _____