Government

**Prescription and Request for BPAP Funding for Adults with**

**Neuromuscular, Musculoskeletal or Spinal Cord Conditions**

 **B-NMS**

The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21, 22 and 27 of the *Health Information Act* and sections

33, 34, 39 and 40 of the *Freedom of Information and Protection of Privacy Act (FOIP)* for the purpose of providing and determining eligibility for health benefits under the *Alberta Aids to Daily Living and Extended Health Benefits Regulation.* If you have any questions about the collection of this information, you can contact Alberta Aids to Daily Living Program, 10th Floor, Milner Building, 10040 – 104 Street NW, Edmonton, Alberta T5J 0Z2 Telephone: 780-427-0731 Fax: 780-422-0968.

Please read the instructions on page 3 prior to completing this form.

Please indicate if the form is for Clients (age 18 or older) who request ventilator support for respiratory insufficiency caused by

 Rapidly progressive neuromuscular conditions, or

 Stable or slowly progressive neuromuscular, musculoskeletal or spinal cord conditions

 Date submitted *(yyyy-mm-dd)*

 Urgent for the following reason(s)

Client requires BPAP for hospital discharge or to prevent hospital (re)admission.

Client starts on BPAP and oxygen at the same time.

Other (specify)

1. Client's Name (Last, First)

PHN Date of Birth *(yyyy-mm-dd)*  **-** -

Address

City Postal Code Telephone Number

2. Respiratory Assessor (Last, First Name)

Designation RRT Other Facility Name

Phone Fax

3. If Client is in the hospital, provide hospital name and unit

Tentative discharge date *(yyyy-mm-dd)*

4. Current Diagnosis

**If Client has a rapidly progressive neuromuscular condition, go to Step 5. For other conditions, go to Step 6.**

5. Clients who request BPAP for respiratory insufficiency caused by rapidly progressive neuromuscular conditions must meet one of the following

a) ABG at rest with PaC02 45 (attach copy)

Yes No

b) PFT with FVC  50% predicted (attach copy)

 Yes No

c) Sniff nasal pressure< 40 cmH20 Yes No d) PI max< 40 cmH20 Yes No

e) Persistent Orthopnea

Yes No

f) PSG with an increase of TcC02  10 mmHg (attach histogram, summary

Yes

 and interpretation)

No

6. Clients who request BPAP for respiratory insufficiency caused by stable or slowly progressive neuromuscular, musculoskeletal or spinal cord conditions must meet one of the following while in a stable state:

a) ABG at rest with PaC02  45 (attach copy) Yes No

b) Orthopnea with a drop in VC of 20% in supine position versus sitting upright

(attach copy)

 Yes No

c) PSG with an increase of TcC02  10 mmHg Yes No

(attach histogram, summary and interpretation)

7. Prescribed BPAP Settings:

Mode S S/T PC AVAPS

IPAP min IPAP max EPAP Rise Rate Ti Vt Ramp 02

Other

8. Preferred BPAP Specialty Supplier

9. Does client require oxygen with the BPAP? Yes No

If yes, the oxygen Specialty Supplier will be the same as the BPAP Specialty Supplier wherever possible.

10. Prescribing Physician Name (Last, First)

Phone Fax

Date *(yyyy-mm-dd)* Signature

This form must be signed by a certified pulmonologist.

11. Comments

**How to Complete the Prescription and Request Form for BPAP Funding for Adults with Neuromuscular, Musculoskeletal or Spinal Cord Conditions**

**This form is for Clients (age 18 or older) who request ventilatory support for respiratory insufficiency caused by rapidly progressive neuromuscular conditions or stable/slowly progressive neuromuscular, musculoskeletal or spinal cord conditions.**

1. Provide Client's name, personal health number and date of birth as they appear on their Alberta Personal Health Card. Provide Client's address, including postal code and the contact number.

2. Provide the name, designation, facility and the contact information of the Respiratory Assessor who completes the request form. The Respiratory Assessor must ensure the information provided to be true and correct.

3. If Client is in the hospital, provide the name of the hospital, the station or unit number and Client's tentative discharge date.

4. Provide current diagnosis:

Client with rapidly progressive neuromuscular conditions must have one of the following diagnoses:

a) Amyotrophic Lateral Sclerosis b) Primary Lateral Sclerosis

c) Progressive Muscular Atrophy

d) Pseudobulbar Palsy

e) Progressive Bulbar Palsy

Client with stable/slowly progressive neuromuscular, musculoskeletal or spinal cord conditions must have one of the following:

a) Stable or slowly progressive neuromuscular disorders, e.g. Post Polio Syndrome.

b) Primary disorders of respiratory muscles, e.g. Muscular Dystrophy.

c) Chest wall deformities leading to restrictive disorders of the lung, e.g., Kyphoscoliosis.

d) Traumatic spinal injuries, e.g. Quadriplegia.

5. Client with rapidly progressive neuromuscular conditions must meet one of the following requirements:

a) ABG obtained at rest with PaC02 greater than or equal to 45 (attach copy).

b) Pulmonary function test showing Forced Vital Capacity (FVC) less than or equal to 50% predicted (attach copy with interpretation).

c) Sniff nasal pressure less than 40 cmH20.

d) PI max less than 40 cmH20.

e) Persistent Orthopnea.

f) PSG showing nocturnal hypoventilation with an increase ofTcC02 at least 10 mmHg (attach histogram, summary and interpretation).

6. Client with stable or slowly progressive neuromuscular, musculoskeletal or spinal cord conditions must meet one of the following requirements obtained while in a stable state (recovered to baseline from any acute illness):

a) ABG obtained at rest with PaC02 greater than or equal to 45 (attach copy).

b) Orthopnea with a drop in Vital Capacity (VC) of at least 20% in supine versus sitting upright (attach copy).

c) PSG showing nocturnal hypoventilation with an increase ofTcC02 at least 10 mmHg (attach histogram, summary and interpretation).

7. Provide the data of the BPAP mode and settings on this request.

8. Provide preferred BPAP Specialty Supplier. It shall be based on Client's needs and Client's current relationship with the Specialty Supplier.

9. If oxygen is approved with the BPAP, the oxygen Specialty Supplier will be the same as the BPAP Specialty Supplier whenever possible.

10. Provide the name, phone number, fax number and signature of the prescribing physician. It must be signed by a certified pulmonologist. No separate BPAP prescription is required.

11. Provide comments if any.