

Prescription and Request for BPAP Funding for Adults with Sleep Disordered Breathing (No PSG)

B-SDB-NO PSG

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.
- This form is for Clients (age 18 or older) who have nocturnal respiratory insufficiency attributed to sleep disordered breathing (including sleep apnea or hypoventilation related to obesity or medication) who are requesting **BPAP** funding. Their **BPAP** titration was performed at the hospital.
- If O₂ is requested to be used with the **BPAP**, the referrer does not need to create a separate O₂ funding authorization.

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:

5. Date of the most current full PFT (yyyy-mm-dd) _____ (attach copy)

FEV1 _____ liters (_____ % pred) FVC _____ liters (_____ % pred) FEV1/FVC ratio _____ BMI _____

Does the Client have severe Chronic Obstructive Pulmonary Disease (COPD)? Yes No

6. Current medications

7. Date of BPAP titration (yyyy-mm-dd)

Before BPAP

ABG pH _____ PaCO₂ _____ PaO₂ _____ HCO₃ _____ (or B.E. _____) SaO₂ _____

Oximetry Average SpO₂ _____ % Lowest SpO₂ _____ %(excluding artifact) After BPAP

ABG pH _____ PaCO₂ _____ PaO₂ _____ HCO₃ _____ (or B.E. _____) SaO₂ _____

Oximetry Average SpO₂ _____ % Lowest SpO₂ _____ %(excluding artifact)

- ABG results before and after BPAP initiation must show improvement of PaCO₂ and PaO₂ level with BPAP therapy.
- Attach copy of ABG results done before and after BPAP titration.
- If overnight oximetry was done, attach copy of the oximetry trend and the summary.

8. A Level 1 sleep study will be arranged prior to the hospital discharge Yes No

- If no, Client is not eligible for BPAP funding. This requirement must be met for the level 1 BPAP titration ensures Client's BPAP settings are optimal.
- Attach copy of level 1 referral.

9. Prescribed BPAP Settings

Mode S S/T PC AVAPS

IPAP min _____ IPAP max _____ EPAP _____ Rise _____ Rate _____ Ti _____ Vt _____ Ramp _____ O₂ _____

Other _____

10. Preferred BPAP Specialty Supplier _____

11. Does Client require O₂ with the BPAP? Yes No

If yes, the O₂ Specialty Supplier will be the same as the BPAP Specialty Supplier whenever possible.

12. Prescribing Physician Name (Last, First) _____

Phone _____ Fax _____

Date (yyyy-mm-dd) _____ Signature _____

- BPAP prescription must be signed by a certified pulmonologist / internist or a physician trained in sleep disordered breathing.

13. Pulmonologist or Specialist following up on the Client in the community

Last Name _____ First Name _____

Phone _____ Fax: _____

14. Comments

How to Complete the Prescription and Request Form for BPAP Funding for Adults with Sleep Disordered Breathing (No PSG)

This form is for Clients (age 18 or older) who have nocturnal respiratory insufficiency attributed to sleep disordered breathing (including sleep apnea or hypoventilation related to obesity or medication) who are requesting BPAP funding. Their BPAP titration was performed at the hospital. If O₂ is requested to be used with the BPAP, the referrer does not need to create a separate O₂ authorization.

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 Respiratory Assessor who completes the request form.
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 Client's current diagnosis.
5. Provide a copy of the most current interpreted full Pulmonary Function Test. Enter FEV1 actual value in liters and its% predicted, actual ratio of FEV1 to FVC and body mass index (BMI). If the Client has severe primary Chronic Obstructive Pulmonary Disease (COPD) and does not have sleep disordered breathing, do not submit this request to RBP.
6. Provide a complete current medication list. If Client has a long list of medications or additional space is required, attach a list.
7. Provide date, location and results of BPAP titration. ABG results before and after BPAP titration must show improvement of PaCO₂ and PaO₂ level with BPAP therapy. Attach ABG results done at daytime wake, before and after BPAP titration. Attach overnight oximetry trend and the summary if done.
8. Assure physician in the hospital will be arranging a post discharge level 1 sleep study prior to the hospital discharge to ensure BPAP settings are optimal. Attach copy of level 1 referral.
9. Provide the data of the BPAP mode and settings (including O₂) on this request.
10. Provide the name of the preferred BPAP Specialty Supplier. It shall be based on Client's needs and Client's current relationship with the Specialty Supplier.
11. If O₂ is approved with the BPAP, the O₂ Specialty Supplier will be the same as the BPAP Specialty Supplier whenever possible.
12. Provide the name, phone number, fax number and signature of the prescribing physician. No separate BPAP prescription is required if this request form is signed by the prescribing physician.
13. Provide the name, phone number and fax number of the pulmonologist or specialist following up on the Client in the community.
14. Provide comments if any.