Alberta Government

Prescription and Request for BPAP Funding for Clients Requiring a Restart of BPAP Therapy

B-RESTART

- This form is completed for Clients who were previously discontinued from BPAP therapy and are now requesting funding to restart BPAP therapy.
- This form must be signed by the physician to confirm agreement with the BPAP therapy restart and also to confirm that the Client still requires BPAP therapy. The physician must be a certified pulmonologist or a physician trained in sleep disordered breathing.

This request needs to be uploaded to the Alberta Blue Cross Online Health Portal for funding to be considered.

Urgent for the following reason(s). **Please contact the Alberta Blue Cross AADL Provider Line 587-756-8629**

☐ 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

Client's Name: _____ PHN: _____

5. BPAP therapy was previously discontinued due to the following reason(s)

☐ a) Client was not compliant with the BPAP therapy.

☐ b) Client could not tolerate the BPAP therapy.

☐ c) Client was placed in a long-term care facility or moved out of the province.

☐ d) Other (specify) _____

6. Rationale to restart the BPAP therapy

7. If the reason for previous BPAP therapy discontinuation is due to 5(a) or 5(b), has there been a discussion with the Client to confirm that the Client is committed to achieving compliance with the BPAP therapy?

☐ Yes ☐ No (Client is not eligible for BPAP funding restart)

8. Prescribed BPAP Settings:

Mode ☐ S ☐ S/T ☐ PC ☐ AVAPS ☐ iVAPS ☐ No substitutions

IPAP min ____ IPAP max ____ EPAP _____ Rate _____ Rise _____ Ti _____ Vt _____ Ramp _____ 0_2 _____

Height (if prescribing iVAPS): _____ Other: _____

9. Preferred BPAP Specialty Supplier _____

10. Prescribing Physician Name (Last, First) _____

Phone _____ Fax _____

Date *(yyyy-mm-dd)* _____ Signature _____

- This form must be signed by the physician to confirm agreement with the BPAP therapy restart and to confirm that the Client still requires BPAP therapy.

11. Comments